Dear Honorable Fred Miller,

I am writing regarding Hospital Safe Staffing and Outlawing Mandatory Overtime #4339. After spending 25 years in retail management, I chose to change careers and at the age of 54, received my RN license. I have been a nurse for two years. Not once have I regretted my decision, although my passion for what I do has brought many tears as well as feelings of happiness.

I work at a local hospital as a Critical Care/Float nurse. Depending on which unit I work in, I can have anywhere from two to seven patients. An average assignment in Critical Care is two to three patients. Normally this is a reasonable assignment; however, if two of the three are high acuity the night becomes very challenging. There have been nights (I work 7p-7:30a shift) on Medical Floor when my case load is seven patients. In my opinion, it is not only impossible to give quality care to my patients, it is a dangerous situation. As you are well aware, the population is aging at a very high rate. This changes the medical needs drastically. We are seeing a tremendous increase in patients who are admitted with a single diagnosis but also have many additional physical and mental problems. For example it is not unusual for an 83 year old patient to be admitted with a diagnosis of Exacerbation of Congestive Heart Failure (CHF). In addition the same patient may have a history of Diabetes, Alzheimer's, COPD-Emphysema, CVA (stroke), MI (heart attack). Along with this history they can usually require assistance with eating, toileting, and dressing. If their Alzheimer's has progressed enough, there is the added challenge of preventing falls and maintaining IV and oxygen lines. It should be apparent to anyone that providing quality care for a senior requires more skill, patience, and time than caring for a typical thirty year old who has one diagnosis and very little health history.

I feel being a nurse is the most wonderful career I could have. My only concern when I enter the hospital is to give safe, quality care to my patients. I take my responsibility very seriously and provide care with the thought, "What if this person were one of my loved ones?" Being in the hospital can be a frightening experience for patients and their families. I want to be able to give them the time they deserve, to answer their questions, give reassurance, hold their hand or give a hug if needed.

To me, having a reasonable nurse/patient ratio is necessary not so I can have a longer break or sit at the nurses station, but to provide my patients with what they need and deserve. A good night for me is a shift where my patients ask, "Am I your only patient?" And they are surprised when I respond that I have "a couple more." I want them to feel they are my top priority.

I have come to the realization that Nursing School is a very small fraction of what is required to become a competent nurse. That can only be achieved with time and experience. The Health Care industry needs to make the position more appealing to attract and keep good nurses. Setting a nurse up for failure by giving impossible case loads or demanding they work overtime is a sure way to force them out of the hospital setting. This is a situation that will likely touch each of our lives at some point.

If I can be of any service pursuing these changes, please feel free to contact me at 517-639-7250.

With great respect,

Linda K. Clark R.N.
1020 Lukesport RD.
Quincy, Mi. 49082

Dear Sir,

I am sending you this to show support for a standard staffing ratio for nurse/patient ratios. I have been a nurse for 37 years and have seen a steady increase in these ratios. I work in an ICU where they force you to take an unsafe assignment to try and keep open the unit and if you refuse you are written up and or suspended. The acuity of patients is not taken into account and for the safety of the patients it is imperative that this bill passes to protect them.

Sincerely,

Susan M Burk-Pfaff RN
3153 Kensington St.
Prescott, MI 48756
989/879.8758

Re; Bill # 4339

My name is Jean Anne Jakobi. I am a registered nurse at Bay Regional Medical Center in Bay City, MI and I'm sorry to say I cannot attend this rally in Lansing today because of the very issue this bill is about — short staffing.

I have been a nurse for almost 34yrs all of which have been at Bay Regional and I have never seen the staffing as short as it is now.

Technology has increased. We have to keep up. Patients in the hospital are sicker than they ever were — insurance companies; the government see to that and yet the working nurse to patient ratio is lower. When a hospital gives you the statistics of nurse to patient ratio they count all the RN's — the nurse directors, the nurse managers, the coordinators, the nurse recruiter, staff development nurses etc etc. That does not give you a true picture of the "trenches" We are dying in the

trenches. We cannot get our breaks and often we do not get our ½° unpaid lunch.

Nurses run around like chickens with their heads cut off "putting out fires" — jumping from one crisis to another and unless you're the pt in the crisis — you get put on hold.

Short staffing is a way of life As a union rep. at our hospital, I see the stacks of short staffing forms and unsafe work conditions the nurses turn in wkly.

We care about our patients. We want to provide the best quality care for them, yet daily care is comprimised as there just is not enough hands to do all that needs to be done.

And then there is the issue of mandatory O.T. Our hospital prides itself in not having mandatory O.T.

yet everyday in the OR the nurses are expected to work 4° beyond their 8° as a "short call" and then their usual noc call also. This is a form of mandatory O.T.

Please do what you can to address these issues with the passage of Bill 4339. I support it whole heartedly and know it's only a start. but something has to be done

Thank You
for listening

Jean Anne Jakobi RN
1621 Midland Rd
Bay City, MI
48706
H - 989 6845343
W 989 667 6705

July 2, 2007

To All Those Concerned About the Future of Healthcare in America:

My name is Susan Craft and I am a registered nurse with over 27 years of work experience. I went into nursing because I wanted to do something that had a positive impact on people's lives; I wanted to do something that I felt passionate about. One of my many roles is to intervene on behalf of my patients. Sometimes that has been in the form of being a facilitator; being the bridge between the patient and the doctor or the patient and their family; to enhance communication and advocate for the patient's needs to be understood and met. I write this to you today as a patient advocate; representing the needs of our patients. We have a serious crisis in this country today. We have had a nursing shortage both here in Michigan and nationally for many years and we have a health care system that has known about it and yet has been in denial about it and has done little to nothing to solve it. The reasons for the shortage are multiple and the reasons for it differ, depending on whether you are talking to a staff nurse, an administrative nurse or a hospital CEO. The bottom line is that we have seen our patients come into the health care system progressively more acutely ill and yet there are less nurses to care for these patients. The hospital's classic response to our staffing shortages are "Sorry, there isn't anyone available", or "You can take this assignment; it's just your organizational skills that need help." I cannot count how many times over the course of my 27 years in nursing that I have heard collegues share how guilty they have felt over what they couldn't get done or how impossible their assignments were and they were worried for their patients; did they give all the medications they were supposed to give and were they the right ones? Many dedicated nurses that have spent 12 hours straight with little to no break for meals are being made to feel guilty for the overtime they generate because there is just too much to do. I for one will always choose my patients and their families needs over doing the necessary paperwork (of which there is way too much). One of the most dangerous places to work , no matter what hospital you work at are the intensive care stepdown units. As stated earlier, our patient population has very high acuity, meaning that they require frequent observation and intervention. On any given day, in a stepdown unit, one nurse may potentially be assigned 5-7 patients, sometimes with an assistant, sometimes you "have to make do without." You basically spend your hours running as fast as you can putting out fires and hoping and praying that you reach these disasters quickly enough before they reach the point of no return. Many times patients experience terminal events because the subtle clues that nurses have been trained to pick up cannot be identified soon enough because the nurse can't get to the patient in time because the workload is too excessive. What if that was your loved one? Nurses want to intervene in a timely manner but you simply cannot spread yourself this thin. The bottom line is that patients are dying because hospitals do not want to spend the money to staff the units properly; that is the dirty little secret. I don't care how much money a hospital will spend on radio,tv spots; if you, or someone you love is in pain and that call light is not answered in a timely manner; that is the bottom line, that is the worst possible type of advertising you can have and the hospitals do not get it; they don't; want to get it because then it will have to cost them something.

I would ask you please to look at the legislation proposed by the National Nurses Organizing Committee to establish nursing ratios here in Michigan and I hope nation wide. The law would establish a strategy to staff units properly based on an acuity tool

that would be evidence based, that accurately reflected the level of care required of the individual patient and staff the unit based on that determination. This has already been done in California and has been met with great success.

A lot can be said about a society by the way it treats its most vulnerable citizens. I, along with many of my fellow R.N.s are ashamed at the way our current system devalues human beings. We want to be an instrument for positive change in the communities we serve. Please help us establish a system that will meet the needs of our patients . We are counting on you, our legislators , that represent us , to do the right thing.

Sincerely,

Susan B. Craft

Susan B. Craft, R.N.

Testimonial for Support

HB 4339

Hello, to all House of Representatives Labor Committee Members,

My name is Jeffrey A. Suhre RN. I am presenting to this committee, Today my personal testimony to support HB 4339. I have been a professional RN licensed in the state of Michigan for nearly 17 years. My professional RN career has included areas of care in the, Emergency Department, Telemetry and Critical Care areas through out various Health Care Systems in the Detroit Metropolitan Area. This bill is intended to provide safe competent RN patient care to all citizens that reside here in this great state, as well as any person that may be visiting our great state. The clinical research that has been done to date, have shown that the greater numbers of patients that are assigned to a nurse, have the greater potentially co relational negative outcomes or near misses. We the citizens here in the state of Michigan have the right to safe competent patient nursing care. I disagree with Susan Mooney-Smith testimony that this legislation would result in the closing of hospital in the state of Michigan, just as she alleged has occurred in the state of California because of similar legislative laws in place there. The research that I have personally done has not found it caused any adverse effects to that state. As well, I am also disputing the statement by Ms. Mooney-Smith that Agency RN's do not provide the same patient care as a facility employed RN's. I have been employed for the past five years as an Agency RN and in all of my personal conversations with appropriately number of patients assigned to my care have not complained to me, nor have I receive any negative feed back from administrative staff.

My personal story for encouraging and supporting the passing of this bill out of committee to the full House of Representatives is as follows. In the summer of 2004 my wife (also an RN for the state of Michigan), was admitted to one of my current places of employment for chest pain and difficulty of breathing. It was a very busy day for admissions to the hospital. I took her from our personal physician office where she had gone for treatment of difficulty in breathing and found to have low pusloximetry reading. She was admitted to the cardiac telemetry care unit (Her former place of employment) from the ER. After spending nearly 8 hours waiting for an available telemetry bed, she was place in the bed. I having to avoid negative consequences for attendance at my place of employment went to work as scheduled. Nearly 20 hours after placement in the room. My wife summonsed me to her room because she had noticed that the telemetry pack showed that there was no signal being sent out (dead battery). After I had found that her cardiac telemetry was not functioning appropriately. I went to the nursing station central monitoring desk and observed that the signal showed a flat line and the screen indicated that the battery needed to be replaced. I then went into the wave review history and discovered that the signal had been out for nearly 3 hours. I thought that's OK, may be the physician had ordered that the telemetry discontinued. I then went to the chart and pulled out the order sheets in front of several colleague RN's and the unit clerk.

I found that the monitor was not ordered discontinued. I summoned the nursing supervisor to the unit. My wife's assigned RN was working a 16 hour shift. I am unaware of this RN's number of assigned patients, but suspect that this number was greater than a safe number. Fortunately my wife did not suffer any ill effects but this is a near miss. This was not the first occurrence of something similar to have occurred here. In those incidences a person died. The afternoon nursing supervisor apologized that this had occurred. This supervisor then stated to me that they would have done the same thing if this would have occurred to them. Sadly this RN was terminated from the hospital. This RN was a single parent. I unfortunately received verbal reprimand from the Assist Nursing Administrator a week later because this was a HIPPA violation. I advised her that I am the assigned medical Durable Power of Attorney representative for my wife. I was then informed that should I do this again in the future I would have disciplinary/corrective action up to and including termination of employment.

In conclusion I would request that all Labor Committee Members act as strong patient advocates to all residents and visitors to the state of Michigan passing legislative HB 4339 out of committee to the full House of Representative floor. By acting in a supportive manner on this legislation our state can begin the process of fixing our nationally broken health care system. Thanks, to all of you for allowing me to present my testimony supporting HB 4339.

Respectfully Submitted by,

Jeffrey A. Suhre RN

Stronger Together

SERVICE EMPLOYEES
INTERNATIONAL UNION
AFL-CIO, CLC

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1691-240C WM 072804

I want to thank Chairman Miller and the House Labor Committee for allowing me this opportunity to testify on behalf of the Service Employees International Union (SEIU) on House Bill 4339. I would also like to thank Representative Wojno and Senator Patterson for their steadfast efforts on safe staffing and mandatory overtime this legislative session as well as previous ones. They have been true champions of these issues. My name is Cynthia Ann Paul; I am the Legislative Director for the Service Employees International Union here in Michigan. Today, I am speaking on behalf of the 1.8 million members of SEIU nationwide (78,000 members here in Michigan) who utilizes our health care system and more than 870,000 health care workers (60,000 here in Michigan) that we represent. SEIU supports House Bill 4339 and Senate Bill 63; we believe that this is the most important piece of legislation that will come before you this legislative session.

SEIU has been committed to achieving quality care and patient safety in all hospitals and health care facilities. A recent study by the Institute of Medicine of the National Academies (IOM) entitled "Substantial Changes Required in Nurses' Work Environment to Protect Patients From Health Care Errors" further bolsters the measures SEIU has been promoting before federal and state legislatures as well as at the bargaining tables over the last decade; that better ***nurse-to-patient ratios***, ***staffing***, ***limits on mandatory overtime*** and ***health care worker involvement in decision-making at every level*** are needed to improve patient safety in our nation's hospitals.

Minimum nurse-to-patient ratios reduces the risk of medical errors and complications by ensuring that nurses have enough time to properly carry out treatments prescribed by physicians, continually assess and monitor patients—and modify interventions accordingly, as well as provide education to help speed recovery and prevent relapses.

There is a growing body of evidence confirming that inadequate staffing levels in hospitals are leading to tens of thousands of preventable injuries, infections, and deaths each year. One study of 168 hospitals in Pennsylvania found that for each additional patient over four in a registered nurse's workload, the risk of death increased by 7 percent for surgical patients. Patients in hospitals with the lowest nurse staffing levels (eight patients per nurse) have a 31 percent greater risk of dying than those in hospitals with four patients per nurse. On a national scale, staffing differences of this magnitude could result in as many as 20,000 unnecessary deaths annually. These findings are contained in the article "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," and appear in the October 23-30 issue of JAMA.

Another major study published in the May 30, 2002, New England Journal of Medicine, shows a clear relationship between inadequate registered nurse staffing in America's hospitals and the risk of deadly complications. In hospitals with higher nurse staffing, there were 9 percent fewer patient complications compared to hospitals with lower staffing.

In the long run, adequate staffing will reduce the cost of medical errors and high turnover rates. Understaffing is taking such a huge financial toll on our health care system that our state and Congress cannot afford not to set safe staffing standards. The Institute of Medicine estimates the national cost of preventable medical errors and complications to be $17 billion a year. In addition, the high turnover rate associated with understaffing dramatically increases hospitals' expenditures for recruitment, training, overtime, and temporary and agency staff. Because it costs a hospital roughly twice as much to replace a nurse as it does to retain one. Safe staffing levels will save money as well as lives.

A particularly devastating side effect of the understaffing crisis is the abuse of mandatory overtime by many health care employers. Health care workers are often mandated to work back-to-back eight-hour shifts or four extra hours on top of a 12-hour shift to fill gaps in staffing. This threatens patient safety. There is no way an exhausted, overworked nurse is as alert and accurate as a well-rested nurse working a regular shift. Mandatory overtime also

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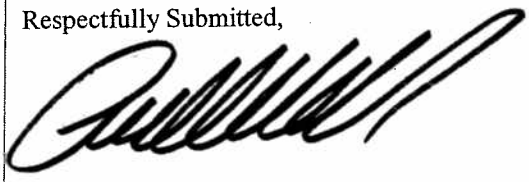
places an incredible stress on family lives of health care workers, particularly when last minute changes have to be made to find childcare or care for elderly parents.

Health care workers stretched to the limit experience higher levels of stress, chronic fatigue, and work-related injuries. These intolerable work practices lead to further burnout and undermine health care worker's sense of professionalism and are driving them out of our hospitals and causing many health care workers to leave their profession entirely and fewer younger people to enter it. Understaffed and unable to provide the highest quality care, more and more nurses are refusing to work in hospitals. In fact, only 1.3 million of the nation's 2.7 million licensed nurses are working in hospitals today. The only way to solve the shortage is to improve the staffing levels and working conditions that are driving them away.

Once again I would like to thank the House Labor Committee for allowing me the opportunity to testify and if you need any additional information, please call me at (517) 482-4886 or visit SEIU's website at "seiumi.org". Along with my testimony, I have also included the results of a poll commissioned by SEIU of 800 registered nurses across the nation.

Respectfully Submitted,



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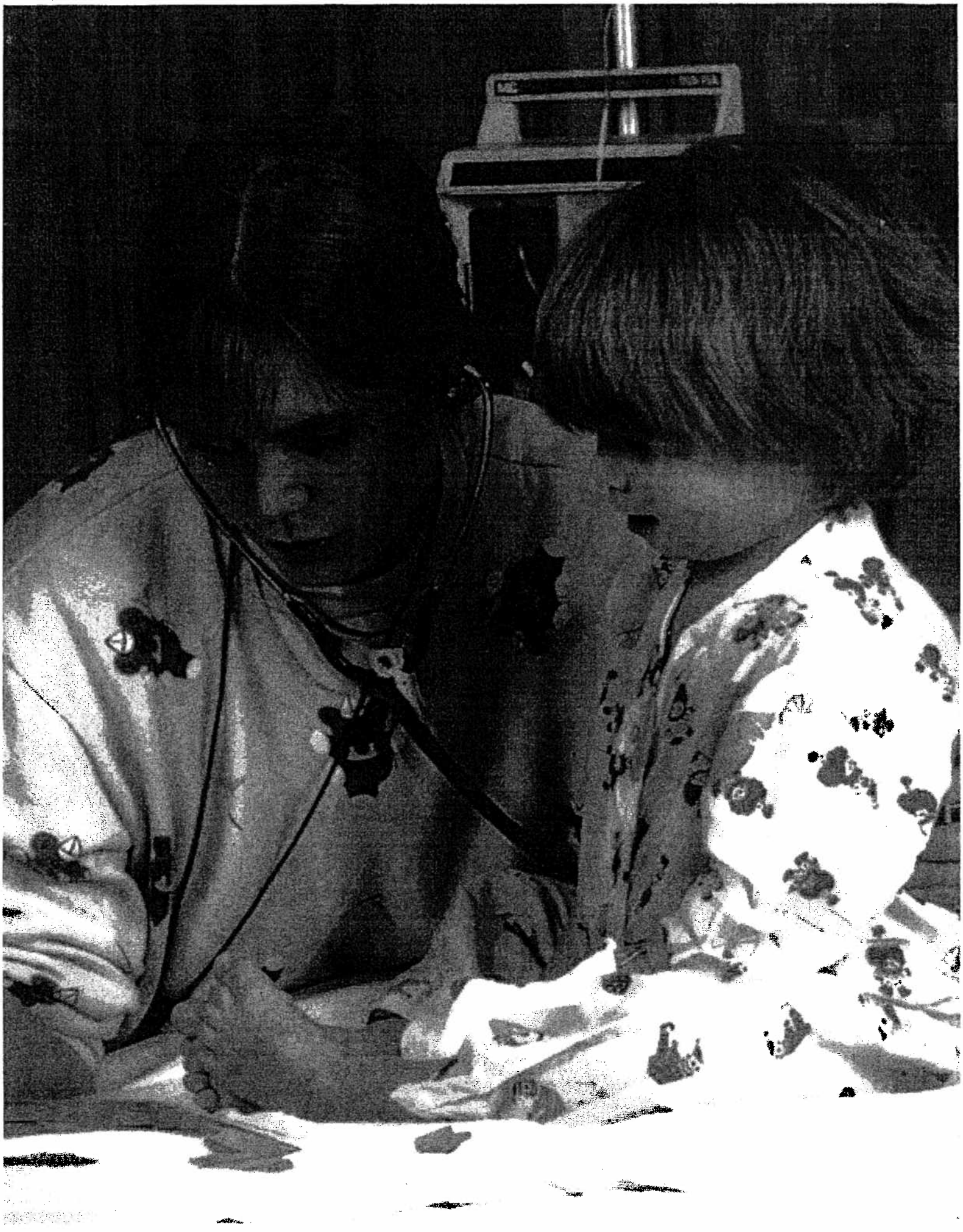


Executive Summary

The rising rate of medical errors in hospitals is fast becoming a national crisis. Ever since the Institute of Medicine released its shocking report in the fall of 1999 showing that medical errors are responsible for 44,000 to 98,000 deaths in hospitals a year, public officials have been studying the crisis and ways to solve it.

According to hospital administrators, the problem was not inadequate staffing but technological changes and other factors. Only recently have they begun to concede that they don't have enough nurses on staff — which they attribute to a growing nursing shortage brought on by demographic changes. In their view, the solution is to expand recruitment and education programs to bring more people into the nursing profession.

But what these initiatives fail to take into consideration is that understaffing was a problem long before a nursing shortage began to emerge. In fact, *the industry created the shortage by cutting staffing levels to the point where nurses — increasingly unable to meet the needs of their patients — began to leave hospitals for less demanding and more rewarding jobs.*

Recruitment initiatives may treat the symptoms, but they won't cure the disease. As long as hospitals are free to cut staffing levels to bare-bones minimums, patients will continue to be at risk — and nurses will continue to leave. Only when hospitals are bound by enforceable safe staffing standards will nurses stay in the profession.

Too few nurses are caring for too many patients in the nation's hospitals.

Nurses in hospitals and related facilities are caring for many more patients today than they did a decade ago. And because of restrictions on hospital admissions and lengths of stay imposed by managed care, the patients in hospitals are more acutely ill and in need of greater care. As a result, nurses across America are sounding the alarm: staffing levels are too low to provide the quality of care their patients need.

To determine the extent to which understaffing is having an impact on medical errors and the emerging nursing shortage, the SEIU Nurse Alliance — more than 110,000 nurses represented by the Service Employees International Union, the nation's largest health care union — commissioned an independent polling firm to conduct a nationwide survey of registered nurses in acute care facilities. In December 2000 and January 2001, The Feldman Group — a Washington, D.C.-based opinion research firm — conducted extensive telephone interviews with a nationally representative sample of 800 registered nurses, as well as over-samples in six states.

The survey confirmed that understaffing is taking its toll on nurses and patients alike.

Nurses don't have enough time to meet the basic needs of their patients.

In hospitals and other acute care facilities, nurses bear the primary responsibility for the care and well-being of patients. It's up to them to continually assess patients, monitor their conditions, modify interventions accordingly, and teach patients to care for themselves. However:

- 58 percent of nurses say that at least once a week on their units, nurses do not have time to provide patient teaching and education.

■ 37 percent say that at least once a week on their units, nurses do not have time to assess and monitor patients' conditions.

When nurses are overloaded, mistakes happen — and patients suffer.

As nurses have less time to spend with their patients, medication errors and other adverse incidents have become a regular occurrence:

■ 34 percent of nurses say that patients on their units experience missed or delayed medication or treatments at least once a week.

■ 8 percent report that the wrong medication or dosage, which can lead to serious complications, is administered to patients on their units at least once a week.

■ 10 percent say that patients on their units acquire infections, which are often the result of delayed medication or treatment, at least once a week.

Most medical errors are caused by insufficient staffing.

A majority of nurses identify understaffing as the cause of medical errors. And the situation, they say, is not improving.

■ 54 percent of nurses say that half or more of the errors they report are the direct result of inadequate staffing.

■ Despite the growing attention focused on medical errors, most nurses say the rate of incidents has remained unchanged during the last year — while fully 30 percent of nurses say the errors have actually increased.

> "The best thing about nursing is that it's rewarding. You feel fulfilled when you take care of patients and when you help them. What's not so good is having eight patients when you should have only four. They should all be closely monitored, but you can't do it because you are running back and forth. When there aren't enough nurses to care for patients, it's a very frightening feeling."
>
> REGISTERED NURSE, PITTSBURGH

The sicker the patient, the greater the risk.

Hospitals are expected to allocate nursing staff in such a way that the patients with the highest acuity level — that is, the patients who are most seriously ill — receive the most care. But that is not always the case.

■ 55 percent of nurses say the methods their hospitals use to measure patient acuity do not do a good job of telling management the number of staff needed in their units.

■ 58 percent of nurses caring for mostly high-acuity patients identify short-staffing as the cause of most medical errors, compared with 46 percent of nurses with mostly low-acuity patients.

The problem is systemic understaffing, not a shortage of nurses.

The nursing shortage is not causing understaffing. Instead, systemic understaffing is causing the nursing shortage. For more than a decade, managed care led hospitals to hold down nurse staffing levels, even as the average acuity level of patients rose sharply.

■ The number of hospital employees on staff for each patient discharge, adjusted to reflect the rise in acuity levels, declined by more than 13 percent between 1990 and 1999.

Deteriorating working and patient care conditions led nurses to leave hospitals.

As far back as 1992 (when there was actually a growing surplus of nurses), understaffing was already damaging working and patient care conditions in hospitals. A national survey by SEIU revealed that, stretched to the limit and increasingly unable to provide the quality of care their patients needed, nurses were experiencing high levels of stress, chronic fatigue, and work-related injuries. Nurses began to leave hospitals for less demanding jobs.

■ The proportion of registered nurses working in hospitals declined from 68 percent in 1988 to 59 percent in 2000.

■ Many nurses left the profession altogether, and fewer young people are entering it. Nursing school enrollment has declined in each of the last six years. As a result, the average age of working RNs has increased 7.8 years since 1983 to 45.2 today.

The industry's response to the growing shortage of RNs is making it worse.

The emerging nursing shortage promises to get much worse. By the year 2020, when baby boomers will be in most need of care, there will be a projected shortage of 400,000 nurses.

But the industry's response to the growing shortage is exacerbating the problem. Nurses are increasingly required to work mandatory overtime and "float" or transfer to units where they lack experience and training. These practices are driving more nurses out of hospitals. According to the recent survey:

■ Nurses in acute care hospitals work an additional 8½ weeks of overtime on average per year.

■ Only 55 percent of acute care nurses plan to stay in hospitals until they retire.

■ 68 percent of nurses say they would be more likely to stay in acute care if staffing levels in their facilities were adequate.

The crisis will not be solved by recruitment and education initiatives alone.

Current initiatives to ease the nursing shortage by expanding tuition assistance and recruitment programs are a step in the right direction. But putting resources into recruitment alone will only create a revolving door. As long as they are overloaded and unable to provide quality care, nurses will continue to face high levels of stress and injuries — and look elsewhere for careers that provide greater rewards and satisfaction.

In today's health care industry, the financial incentives to understaff hospitals and other health facilities are as intense as they've ever been. And yet, with remarkably few exceptions, the nation's hospitals are unregulated and oversight of the quality of care is weak. To make matters worse, no federal "whistleblower" protections or mandatory overtime restrictions exist to specifically address the concerns of nurses and other health care employees.

The only true solution: safe staffing standards all hospitals must follow.

To address systemic understaffing and improve working and patient care conditions in the industry, the nation needs laws and policies to:

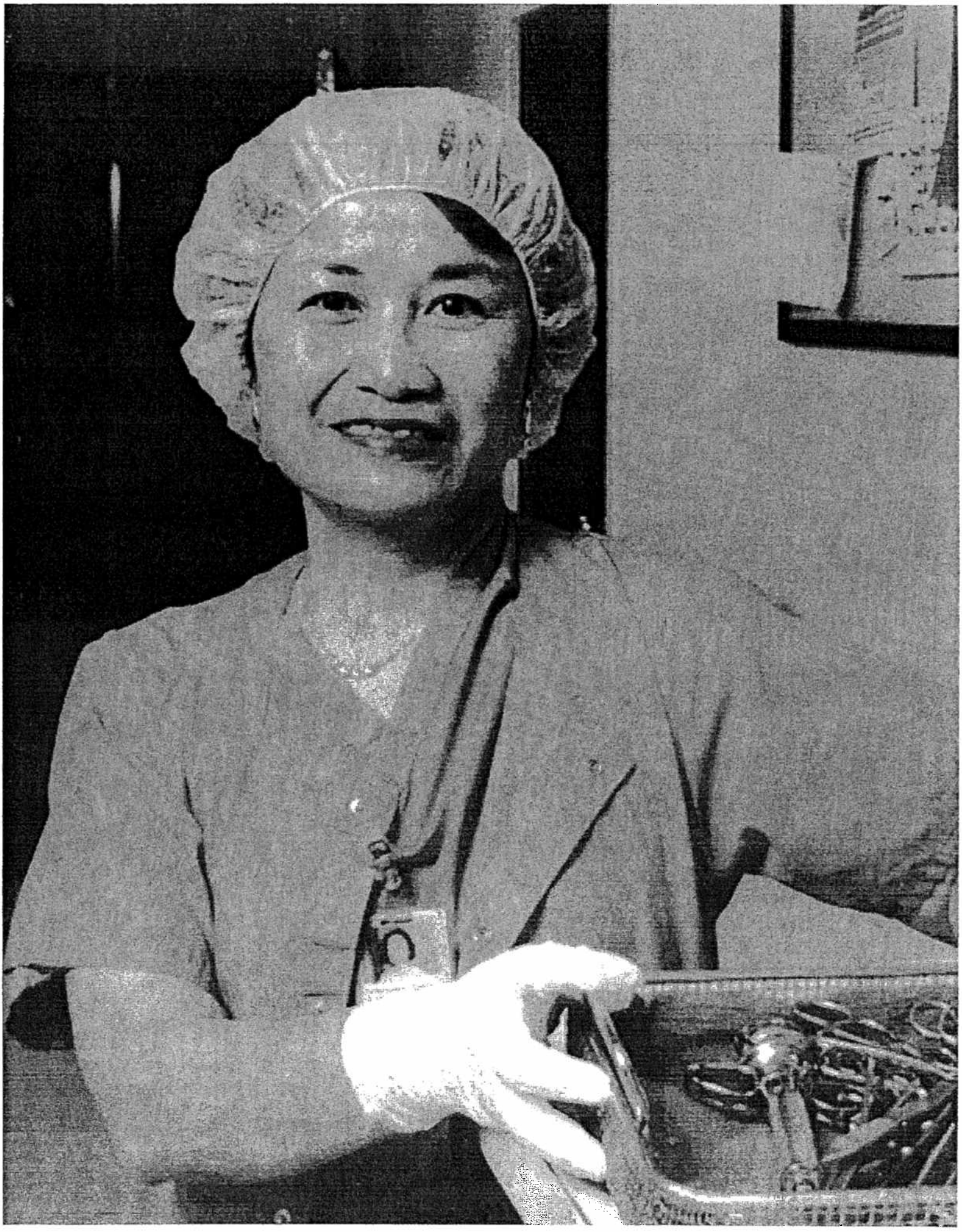
■ ***Set enforceable minimum staffing standards*** linked to the acuity of patients to ensure quality care in hospitals, emergency rooms, and outpatient facilities. Safe staffing standards should be accompanied by a ban on mandatory overtime and set maximum hours for nurses, as well as protections for nurses who blow the whistle on staffing problems.

■ ***Establish meaningful oversight and inspection procedures*** for the nation's hospitals and other facilities. The industry's self-monitoring system under the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) must be reformed, and the oversight and regulations of the Health Care Finance Administration (HCFA) must be strengthened.

■ ***Ensure that direct-care nurses and other caregivers have a voice*** in the development of hospital staffing plans and in the oversight and enforcement of staffing standards.

■ ***Promote retention — not just recruitment*** — in the nursing profession with initiatives to improve working conditions and strengthen the nation's job safety laws.

Ultimately, the nation must also address the growing ranks of the uninsured — and guarantee affordable, quality care for everyone.



The Truth Behind the Crisis In America's Hospitals

What's missing in the debate about staffing and patient care is the voices of nurses

Dramatic changes in the U.S. health system have given rise to mounting concerns about the quality of care in our nation's hospitals and other health facilities. During the past decade, as the shift toward managed care and the pressure to cut costs intensified, more and more patients were finding it difficult to get the care and attention they needed. From the front lines, nurses were warning that staffing levels were not keeping up with the rising acuity (severity of illness or injury) of patients and the quality of care was deteriorating rapidly.

Despite the concerns that were surfacing, hospitals and other health care providers continued to maintain that nurse staffing levels in their facilities were adequate and safe. Even when the Institute of Medicine (IOM) issued its startling report in the fall of 1999 showing that medical errors were causing as many as 44,000 to 98,000 deaths in hospitals each year[1], the industry's response was to attribute them to technological changes and other factors unrelated to staffing levels.

Recently, however, America's hospitals have begun to concede that they don't have enough nurses on staff. The problem, they say, is that there's a new and serious shortage of nurses brought on by demographic changes in the population. In their view, the only way to solve the problem is through expanded recruitment and education efforts to attract more people into the nursing profession.

But what these initiatives fail to acknowledge is that *understaffing was a problem long before a shortage of nurses began to emerge.* In fact, the industry itself created the shortage by cutting staffing levels to the point where nurses — increasingly unable to meet the needs of their patients — began to leave hospitals for less demanding jobs.

Today, in many parts of the country, hospitals are struggling to attract and retain registered nurses. Projections for the future suggest that this problem will only get worse. But initiatives to draw more young people into nursing schools will only treat the symptom, not the disease. As long as hospitals and other health care institutions are free to cut staffing to bare-bones minimums, the quality of patient care will continue to be at risk — and nursing will become an increasingly unrewarding and unattractive profession.

To ensure that patients receive the quality of care they need, America needs *safe staffing standards that all hospitals and health facilities must follow.* As it stands, hospitals are largely unregulated; the only monitoring system for the quality of care is a voluntary one established by the industry itself. Unless and until hospitals are bound by meaningful and enforceable standards for nurse staffing levels, patients will continue to be at risk — and nurses will continue to leave the profession.

A VOICE FOR NURSES: THE SEIU NURSE ALLIANCE

How did this situation come to be? One reason is that nurses have had relatively little input — not only in the way hospital staffing plans are developed and executed, but also in the public policy discussions surrounding the increase in medical errors and the growing nursing shortage. More often than not, decisions that affect nurses and patients are made by administrators and insurance companies. Nurses bear the ultimate responsibility for the care of patients in hospitals, yet their voices are rarely heard.

Increasingly concerned about what's happening to the quality of care, growing numbers of nurses throughout the country are joining together in unions as a way to more effectively advocate for their patients and their profession. By negotiating for improvements in staffing and other working and patient care conditions, nurses represented by the Service Employees International Union (SEIU) Nurse Alliance throughout the country are enhancing their hospitals' ability to recruit and retain nursing staff.

In some cases, SEIU nurses are negotiating contracts that specify staffing standards and nurse-to-patient ratios. In others, they are bargaining for joint decision-making in the process of determining how staffing levels will be set. Their contracts also include restrictions on mandatory overtime, orientation guidelines, professional pay and benefits, recruitment and retention programs, and other measures to protect the safety of nurses and patients.

But nurses know that the crisis in health care today will not be solved without broad policy changes that address the industrywide pressure to cut costs and reduce the quality of care. Increasingly, they are turning to unions for a voice in public policy decisions as well.

For more than a decade, nurses represented by the SEIU Nurse Alliance have been challenging lawmakers and government agencies to do more to address deteriorating standards in the health care industry. In 1992, SEIU conducted a nationwide survey of 10,000 nurses, which found that understaffing was causing negative patient outcomes as well as high rates of stress, fatigue, and injuries among nurses.[2] The report warned that "poor staffing conditions and deteriorating patient care have demoralized nurses to the point where many are ready to 'vote with their feet'" — a forecast that appears to have been right on the mark.

The results of that survey were so alarming that Congress commissioned the IOM to study nurse staffing levels in hospitals and nursing homes. What the IOM found was a shocking lack of available data on the relationship between staffing levels and the quality of care. In 1996, the IOM called for a national research investigation of hospital practices relating to quality patient care.[3] Unfortunately, funding for the study didn't materialize until it was appropriated in the fiscal year 2001 federal budget.

In the meantime, SEIU nurses have worked to win passage of a variety of state laws that protect patients' rights and nurses' professional standards. They led a drive

> "No nurse should be left working alone on her unit. It's a potentially disastrous situation, especially in units that are closed and isolated. It used to be that if I had an emergency, I had to go down the hallways that connects to OR, or go through two fire doors to pediatric intensive care to ask another nurse for help. Now, through our union contract, we have a guarantee that no nurse will work alone. Things are much safer now."
>
> REGISTERED NURSE, SEIU NURSE ALLIANCE MEMBER, FORT LAUDERDALE, FLA.

to win 15 state laws as well as a federal law to prevent dangerous needlestick injuries by putting safe needle devices in the hands of nurses and other caregivers. They also drew national attention to the epidemic of work-related strains and injuries in the health care industry.

The SEIU Nurse Alliance also has been working to increase awareness about the link between staffing levels and the quality of care on several national policy fronts, as well as raising questions about inadequate oversight of the nation's hospitals. By calling for major reforms of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), an agency operated by the hospital industry itself, the Nurse Alliance ultimately persuaded the agency to amend its inspection procedures to allow for interviews with nurses and other caregivers without managers present, and to eliminate the notice it provides on its random sampling of so-called unannounced hospital visits.

When the Inspector General of the U.S. Department of Health and Human Services (HHS) released a report in 1999 confirming that the hospital industry's self-monitoring process was "unlikely to detect substandard patterns of care[4]," SEIU responded by calling for the use of surprise visits on all JCAHO inspections, input from nurses and other hospital employees, confidentiality and whistleblower protections for caregivers who provide information, and public disclosure of inspection results. SEIU's proposed reforms were attached as an appendix to the HHS report.

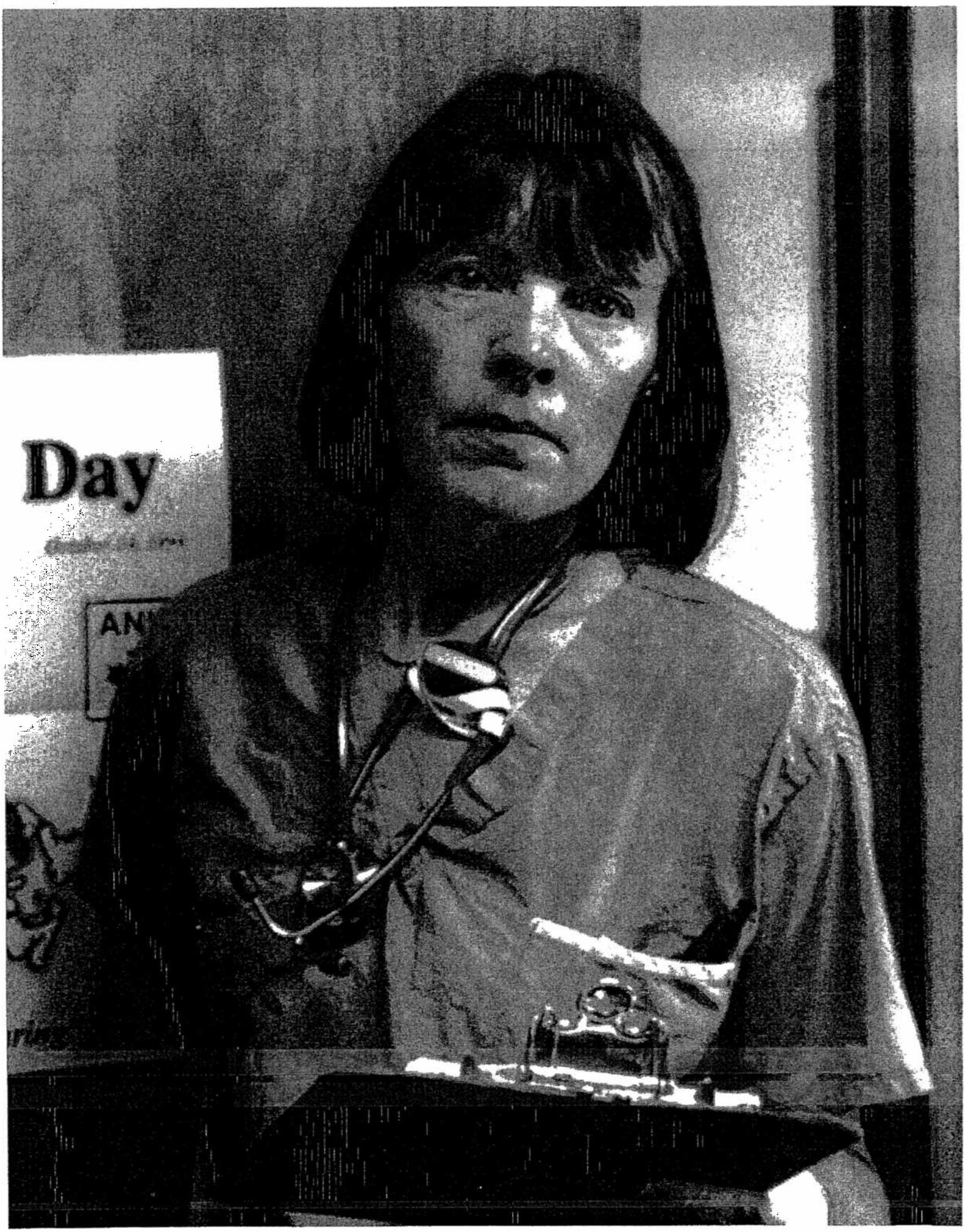
ABOUT THIS STUDY: PURPOSE AND POLLING METHODOLOGY

Now that a severe nursing shortage looms on the horizon, policymakers and hospital administrators are anxious to find ways to recruit more nurses into the profession. But programs to make the nursing profession more attractive are not likely to succeed without the participation and input of nurses. Perhaps more to the point, efforts to retain as well as attract more nurses are likely to fail unless administrators and public officials recognize the role understaffing has played in creating the nursing shortage.

To help bring the voices of nurses into the public policy discussion, the SEIU Nurse Alliance prepared this study on the relationship between staffing and the quality of care and the origins of the emerging nursing shortage. It reflects the view and opinions of nurses throughout the country gathered from many sources, including meetings with nurses throughout the country and a series of focus groups conducted by an independent polling firm.

In addition, the SEIU Nurse Alliance commissioned a nationwide survey of registered nurses in acute care facilities. In December 2000 and January 2001, The Feldman Group, Inc. — an independent national polling firm — conducted extensive telephone interviews with a base sample of 800 registered nurses, as well as over-samples in six states. Interviews were conducted with a total of 2,737 acute care non-managerial registered nurses; interviews with nurses in over-sampled states were downweighted to accurately reflect each state's proportion of the national population of nurses.

Survey respondents were drawn randomly from registries of nurses throughout the country. All interviews were conducted by telephone between Dec. 13, 2000, and Jan. 20, 2001 by professional interviewers under supervision of The Feldman Group. Respondents were screened for employment status and to assure that they provide direct patient care in an acute care hospital. Calling hours included both days and evenings to accommodate nurses working on different shifts. Each phone number was dialed on at least three separate occasions before it was discarded. With 800 weighted interviews, the margin of error for the total sample is plus or minus 3.5 percent.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PART ONE

Poor Staffing Leads to Poor Patient Care

With too few nurses caring for too many patients, the quality of care is deteriorating fast

The national Institute of Medicine (IOM) shocked the nation in the fall of 1999 with the release of its report called *To Err Is Human: Building a Safer Health System.* The IOM estimated that medical errors in the nation's hospitals cause between 44,000 and 98,000 deaths each year. Every year, according to the IOM, more people die from medical errors than they do from motor vehicle accidents (43,453), breast cancer (42,297), or AIDS (16,456).[5]

While the IOM report exposed a national crisis, it did not explore one of the primary causes of it: understaffing. Nurses in hospitals and related facilities are caring for many more patients today than they did a decade ago, and those patients are more acutely ill and in need of greater care. As a result, nurses are not always able to deliver the quality of care their patients need — a reality confirmed by the recent survey of registered nurses in acute care hospitals commissioned by the SEIU Nurse Alliance (see "About This Study," page 7). Not only are adverse incidents such as medication errors and missed treatments happening with frightening regularity, but they are often the result of insufficient staffing.

> "Medication errors usually are not reported, because usually no long-lasting damage is done. If there is a bad outcome, a report is filed. The doctor may or may not be called when a simple error is made. But the result of a medication error can be a double whammy because sometimes, in a two-person room, the wrong bed gets the other's meds."
>
> REGISTERED NURSE, LAS VEGAS

Nurses don't have enough time to meet the basic needs of their patients.

Patients are admitted to hospitals for one reason, and that's because they need around-the-clock nursing care. Nurses bear the primary responsibility for the care and well-being of hospital patients. They help patients navigate an often confusing and difficult medical system. They not only carry out the treatments prescribed by physicians, but they explain procedures to patients and provide education to help speed recovery and prevent relapses. At the same time, nurses continually assess patients, monitor their conditions, and modify interventions accordingly.

However, nurses often lack the time to carry out even these basic vital functions.

■ *Among nurses surveyed, 58 percent say that nurses on their units do not have time to provide patient teaching and education at least once a week.* More than one-fourth (28 percent) say this happens at least once a day on their unit. This type of omission can be serious given that patients

today are being sent home from the hospital earlier — and sicker — in an effort to reduce lengths of stay. When nurses don't have time to explain to patients or their families how to care for themselves, it can lead to "rebounding" — where patients return to the hospital emergency room due to complications.

■ *Fully 37 percent say nurses on their units do not have time to assess and monitor patients' conditions at least once a week.* Even in intensive care units, where monitoring of patients is most critical, 29 percent of nurses say that patients in their units go unassessed at least once a week.

When nurses are overloaded, mistakes happen — and patients suffer. As nurses have less and less time to spend with their patients, medication errors and other adverse incidents have become a regular occurrence.

■ *More than one-third (34 percent) of nurses say that missed or delayed medication or treatments occur at least once a week on their units.* Nurses on general medical-surgical floors (44 percent) and intensive care units (42 percent) are even more likely to see patients miss treatments or medications on a weekly basis.

TABLE 1
NURSES LACK TIME FOR EDUCATION AND ASSESSMENT

Percent of nurses who say the following occurs at least once a week on their units:

	Lack of time for patient education or training	Not enough time to assess each patient on each shift
All units	58%	37%
General medical-surgical	63%	44%
Intensive care	58%	29%
Obstetrics	53%	40%
Labor & delivery	58%	31%
Operating room	42%	34%
Recovery room	36%	22%
Pediatrics	54%	23%
Psychiatry	52%	47%
Emergency room	68%	50%
Step-down	65%	46%

Source: The Feldman Group Inc., SEIU Nurse Alliance, January 2001

■ *Incidences of the wrong medication or dosage occur at a lower, but still alarming, rate.* Of the surveyed nurses, 8 percent report that the wrong medication or dosage — which can lead to serious complications — is administered to patients on their units at least once a week.

■ *Hospital-acquired infections, which are often the result of delayed medication or treatment, occur on a regular basis.* Fully 10 percent of nurses say that patients on their units acquire infections at least once a week.

Most medical errors are caused by insufficient staffing.

While the IOM offered a variety of other explanations for the rising rate of medical errors, most notably a lack of performance standards and accountability[6], nurses identify understaffing as the primary cause — a problem with the system that is only getting worse.

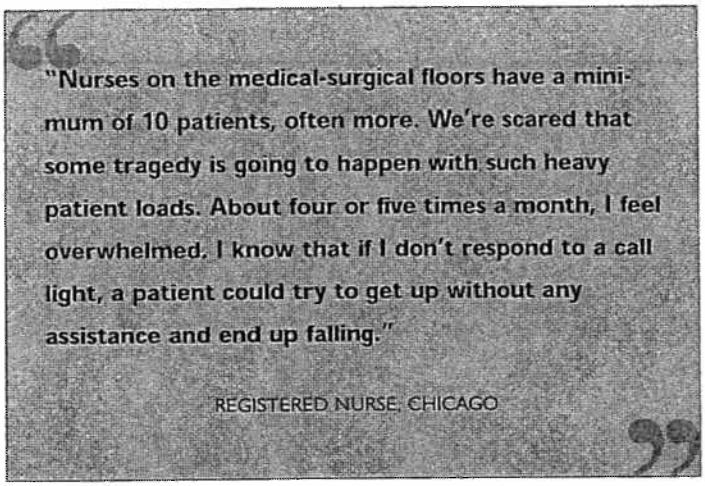
■ *Nurses say understaffing is responsible for most medical errors.* A majority of nurses surveyed (54 percent) say that half or more of

TABLE 2
MEDICAL ERRORS ARE A FREQUENT OCCURRENCE

Percent of nurses who say the following occurs at least once a week on their units:

	Delayed or missed treatment or medication	Patients received the wrong medication or dose	Hospital-acquired infections
All units	34%	8%	10%
General medical-surgical	44%	8%	10%
Intensive care	42%	12%	18%
Obstetrics	24%	4%	6%
Labor & delivery	36%	9%	13%
Operating room	15%	5%	5%
Recovery room	11%	1%	1%
Pediatrics	25%	1%	4%
Psychiatry	34%	14%	9%
Emergency room	34%	6%	6%
Step-down	38%	9%	13%

Source: The Feldman Group Inc., SEIU Nurse Alliance, January 2001



the errors they report are the direct result of inadequate staffing; 22 percent believe that all or almost all of the incidents are caused by insufficient staff.

■ *Despite the growing attention focused on medical errors, the situation is not improving.* Most nurses (54 percent) say the rate of incidents has remained unchanged over the last year — while fully 30 percent of nurses say the errors have actually increased.

The sicker the patient, the greater the risk.

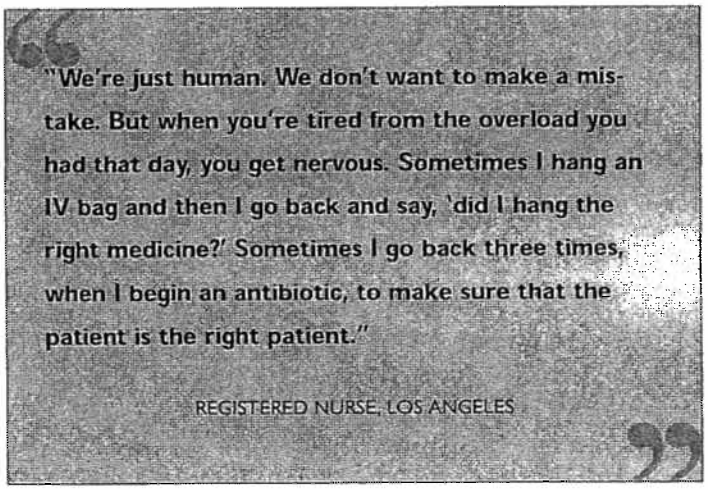
Because managed care has driven down the number of hospital admissions and average lengths of stay, patients in hospitals today are much sicker than they once were. Using a tool for measuring acuity or other system for classifying patients, hospitals are expected to set staffing levels in such a way that the patients with the highest acuity — that is, the patients who are most seriously ill — receive the most care. But that is not always the case.

■ *Many hospitals fail to measure or determine staffing according to acuity.* Only 62 percent of nurses say their hospitals do measure patient acuity. Of those nurses, 55 percent say the acuity tools their hospitals use do not do a good job of telling management the number of staff needed in their units, and only 51 percent say the hospital routinely sets staffing levels in accordance with the acuity tool.

■ *Nurses with more acutely ill patients are more likely to report problems with understaffing.* Fully 58 percent of nurses caring for mostly high-acuity patients identify short-staffing as the cause of most medical errors, compared with 46 percent of nurses with mostly low-acuity patients. Nurses with mostly high-acuity patients (36 percent) are also more likely than nurses with mostly low-acuity patients (24 percent) to say medical errors have increased during the last year.[7]

Fear of retaliation keeps nurses from speaking out.

The high rate of reported medical errors is the tip of the iceberg. Nurses say that many, if not most, such incidents go unreported — largely because nurses and other hospital employees often fear retaliation for speaking



out when understaffing is threatening the quality of care.

Nurses and other health professionals often see employees being penalized for, or afraid to speak up about, problems at work, according to a nationwide survey conducted in October 1997. Most (54 percent) survey respondents said it happens at least occasionally; 24 percent said it happens a fair amount or a lot.[8]

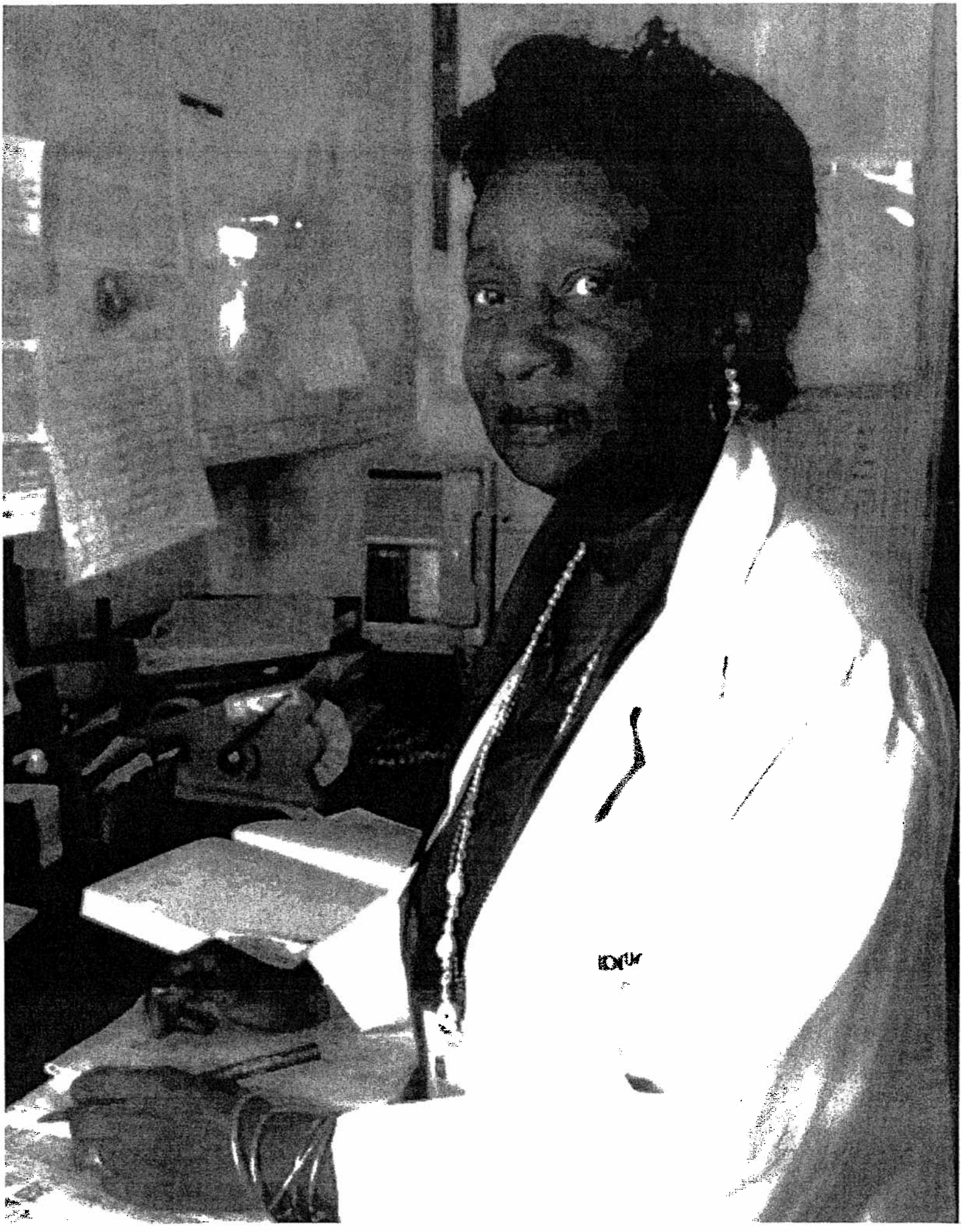
Most health care employees who blow the whistle on short-staffing and poor patient care have no legal protections against retaliation. Federal whistleblower laws are narrow in coverage and do not apply specifically to the health care industry. Even states that have attempted to fill the void by passing their own whistleblower laws do not provide the comprehensive protections needed for nurses and other health care employees.

MORE NURSING CARE MEANS BETTER PATIENT OUTCOMES

When nurses have less time to spend with patients, how does that impact on patients' recovery? What is the relationship between hours of nursing care and patient outcomes? Precise answers to those questions have been hard to come by because little hard data exists. Until recently, few studies had been conducted — and hospitals, which currently enjoy a great deal of flexibility in devising their own staffing plans, have had little incentive to undertake them.

But as more medical research gets underway, the body of empirical evidence showing that more nursing care means better patient outcomes is growing.

One study released in 1998, for example, found that an extra hour of nursing attention per surgical patient each day cut the patient's risk of urinary tract infection by nearly 10 percent and the risk of contracting pneumonia by 8 percent.[9] Another study that same year found that a higher proportion of care by registered nurses results in lower rates of medication errors and patient falls.[10] These and other studies are confirming what nurses already know — that as hospitals cut back on nurse staffing levels, patients suffer the consequences.



PART TWO

The Problem Is Systemic Understaffing, Not the Nursing Shortage

With all the attention focused on the nursing "shortage," the root cause of the problem is often hidden from view

The emerging nursing shortage has captured the nation's attention. Many hospitals are struggling to fill vacant nurse positions. Extensive media reports are warning that the baby boom generation will not have enough nurses to provide care for them when they need it most. And policy-makers are calling for new programs to recruit more people into the nursing profession and provide more funding for nursing schools.

But while the current nursing shortage is exacerbating the understaffing problem, it is not the primary cause of it. In the new managed care environment, understaffing in hospitals is systemic and deliberate. Perhaps more to the point, understaffing led to the current nursing shortage — not the other way around. The deteriorating working and patient care conditions created by understaffing are driving nurses out of hospitals — and driving people away from the nursing profession.

> "You're doing the nurturing. You're doing the caring and reaching out to the whole family, everybody that is involved with this particular patient. In the end, the nurse makes the difference in terms of the hospitalization; whether it's a good outcome, bad outcome, a satisfying experience or an unsatisfying experience. And I think when you make a difference, it makes you proud of what you're doing."
>
> REGISTERED NURSE, SYRACUSE, N.Y.

Understaffing was a problem long before the nursing shortage emerged. The U.S. health care industry has been expanding for decades — and will continue to do so as the population ages. Overall employment of nurses and other hospital employees has grown. But for more than a decade, hospitals have been cutting back on nurse staffing levels, even as the average acuity level of patients rose sharply.

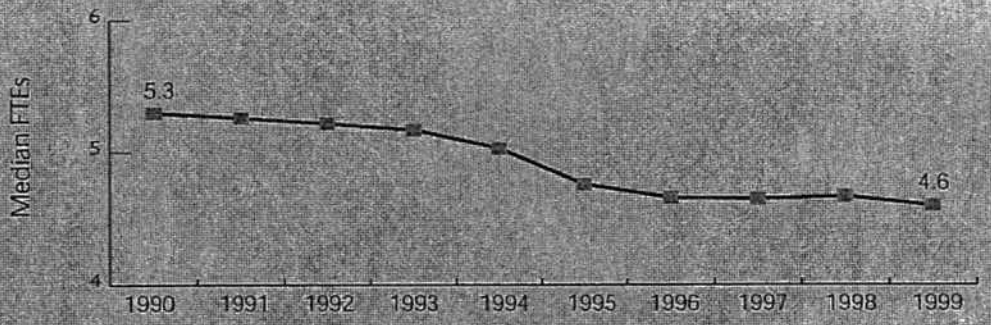
Ever since the 1985 introduction of Medicare's fixed price payment system (diagnostic related groupings) and the subsequent growth of managed care, the primary goal for hospitals has been to cut costs. Hospital administrators embarked on a course that involved keeping patients out of hospitals and cutting costs wherever possible — particularly among registered nurses, who make up the largest share of hospitals' labor costs.

Over the years, hospital admissions were sharply reduced, primarily by shifting to outpatient care. Patients admitted to hospitals were sicker and discharged after shorter lengths of stay. The result was a huge increase in the average acuity of patients, without a corresponding increase in staff.

■ *While the average hospital patient got sicker, the amount of hospital staff per patient dropped.* The median number of hospital employees on staff for each 100 patient discharges, adjusted to reflect the rise in acuity levels, declined by more than 13 percent between 1990 and 1999 (see chart below).

WHILE ACUITY RISES, THE NUMBER OF HOSPITAL STAFF PER PATIENT GOES DOWN

Median full-time equivalents (FTEs) per 100 discharges, adjusted to reflect the complexity of the case mix



Source: "The Comparative Performance of U.S. Hospitals: The Sourcebook," Baltimore: HCIA, 2001 and 1995, "Full-Time Equivalent Personnel per 100 Adjusted Discharges, Case Mix-Adjusted," 2001 and 1995

A MAJOR INVESTMENT FIRM EXPLAINS THE ORIGINS OF THE CURRENT SHORTAGE

"The response [to managed care and Medicare reimbursement cuts] by the hospital industry ... was to downsize. This downsizing was achieved largely through staff reductions, both clinical and non-clinical.

"While utilization of services and, certainly, payments for those services, did decline for a period of time, the drastic fall-off in utilization called for by the 'experts' did not materialize, and, in our opinion, is not likely to do so. However, the damage was done.

"The message was clear: Hospitals were not a good place to work. Not only did one stand a good chance of losing one's job, there were fewer and fewer people around to do the work that had to be done. And pay raises were practically unheard of. Bonuses were really unheard of.

"So, the hospital industry unwittingly set in motion many of the events leading to the nurse staffing challenges it currently faces."

—Excerpted from "Hospital Staffing: Brother Can you Spare a Nurse?," Deborah J. Lawson, Salomon Smith Barney, Dec. 14, 2000.

Nurses and patients alike suffer the consequences of understaffing.

At least a decade ago, with higher loads of sicker patients in their charge, nurses were growing concerned about the quality of care they were able to deliver. Even though there was actually a growing surplus of nurses, understaffing was already taking its toll — not only on patients, but on nurses themselves.

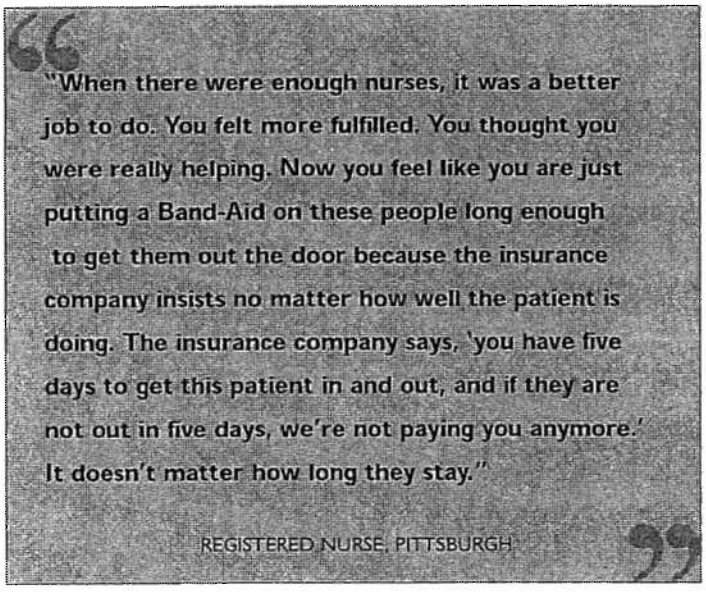
■ *A national survey in 1992 revealed that, stretched to the limit and increasingly unable to provide the quality of care their patients needed, nurses were experiencing high levels of stress, chronic fatigue, and stress-related illnesses.* Seven of 10 nurses participating in SEIU's National Nurse Survey reported that staffing levels in their workplaces were often inadequate. Accidents and medical errors were on the rise, occurring twice as often on short-staffed units as on adequately staffed units. And nurses had begun suffering from the stress of trying to do too much with too little, experiencing chronic fatigue and stress-related disease at rates much higher than the general population.[11]

■ *Nursing has become one of the nation's most dangerous occupations.* Unlike other industries, the rate of occupational injury and illness in hospitals is increasing. Back and neck injuries as well as slips and falls are more likely to happen when nurses are understaffed, rushing from patient to patient to try to keep up. In 1999, the occupational grouping of "RNs, nursing aides, and orderlies" reported 101,400 work-related illnesses and injuries resulting in lost workdays — a number that was second only to truck drivers (141,000). Registered nurses alone experienced 25,700 such illnesses and injuries in 1999 — an increase of 700 from the previous year.[12]

While nurses were stretched further and expected to do more than ever before, hospital administrators were holding down their compensation. Historically, nursing has been an undervalued profession; nurses' pay has never been commensurate with their level of skill, experience, and education. By the mid-1990s, RN salaries were falling behind inflation. Real wages for RNs rose only .3 percent between 1990 and 1994 and actually declined 1.5 percent between 1994 and 1997.[13]

Nurses began to leave hospitals for less demanding jobs.

Throughout much of the last decade, deteriorating working and patient care conditions were driving many nurses to leave full-time employment in hospitals. Several recent studies, including two examining the health workforces in California and New York, confirmed that understaffing, physical demands, and stresses of the job are among the factors affecting the states' supply of RNs.[14]



■ *Many RNs left hospitals to work in less-stressful environments.* The proportion of registered nurses working in hospitals declined from 68 percent in 1988 to 59 percent in 2000.[15]

■ *While some nurses are leaving the profession altogether, fewer young people are entering it.* According to the American Association of Colleges of Nursing, nursing school enrollment has declined in each of the last six years.

■ *As a result, the average age of working RNs has increased 7.8 years from 37.4 in 1983 to 45.2 in 2000.* In fact, the average age of the RN workforce is increasing twice as fast as the workforce as a whole.[16]

The industry's response to the growing shortage of RNs is making it worse. Today, in regions throughout the country, nursing shortages are reaching crisis levels — and promise to get much worse. By the year 2020, when baby boomers will be in most need of care, there will be a projected shortage of 400,000 registered nurses.[17]

But the industry's response to the growing shortage has been to accelerate many of the policies and practices that have been driving nurses away in the first place.

Hospitals are relying on more agency and contract nurses to "fill in." Nurses are increasingly expected to "float" or transfer to units where they lack the experience and training. But what is putting the most strain on nurses, as well as their families and patients, is an excessive amount of overtime.

■ *Nurses work an average 8½ weeks of overtime per year.* According to the recent survey commissioned by the SEIU Nurse Alliance, nurses work an average 6.5 hours of overtime each week.

For other occupations where public safety is affected by excessive hours of work, such as pilots and air traffic controllers, mandatory overtime is restricted by law. No such restrictions exist for nurses and other caregivers. As a result, to compensate for a lack of adequate core staffing, hospitals increasingly require nurses to work overtime.

HOSPITAL EXECUTIVES' 'ADVICE' ON MANAGING NURSES

"Nurses ... will work until they are burned out. They blame the company and then jump ... You must have a solid PRN [as-needed per diem] staff to balance the holes in your schedule ...

"Agency nurses are used only as a last alternative. Facilities that use a lot of agency nurses usually end up with quality and documentation problems and low morale with permanent staff. Using your own nurses to staff your overtime is best because you have continuity of care."

—Published in "Staffing Watch," Hospitals and Health Networks, February 2001

Unfortunately, when exhausted nurses are forced to work additional hours beyond their shift, the risk of medical errors occurring becomes even greater.

Not surprisingly, many nurses — even those relatively new to the profession — are looking for a way out of hospitals. According to the recent survey:

■ *Only 55 percent of acute care nurses plan to stay in hospitals until they retire.* Nearly one in five (19 percent) say they will pursue nursing in a non-hospital setting, 11 percent will seek early retirement, and 9 percent will look for a career outside of nursing.

■ *Even nurses under age 35 are already thinking about alternatives.* Only 43 percent plan to stay in acute care until they retire; 32 percent say they will pursue nursing in a non-hospital setting, while 19 percent say they are either seeking another career or planning to retire early.

■ *But if working and patient care conditions were improved, nurses would stay.* Fully 68 percent of nurses say they would be more likely to stay in acute care if staffing levels in their facilities were adequate.

What America's nurses are saying is clear: The only way to alleviate the nursing shortage is to create the professional standards and conditions that will attract and retain more nurses.

PART THREE

Safe Staffing Standards Are the Only True Solution

The staffing and patient care crisis will not be solved by recruitment and education initiatives alone

Now that the emerging nursing shortage is making it difficult for hospitals and other institutions to fill vacancies, lawmakers are under pressure to increase funding for nursing schools and other educational programs.

To be sure, increased financial support for nursing education and recruitment is welcomed not only by health care employers, but by nurses who are deeply concerned about the dwindling interest in their profession. In particular, nurses are calling for innovative ways to expand the pool of potential nurses — such as to remove barriers for other health care workers pursuing nursing careers and to reach out to racially and ethnically diverse populations, men and women alike.

But nurses also know that expanding nursing school enrollment alone will not solve the problem. In today's health care industry, the financial incentives to understaff hospitals and other health facilities are as intense as they've ever been. As long as systemic understaffing in the industry remains, so will the working and patient care conditions that have led too many nurses to leave — and too few to enter — the profession.

One of the basic tenets of nursing is to treat the whole patient. Nurses recognize that the cure for the staffing crisis must be a holistic one. Recruitment and education initiatives may ease some of the symptoms, but the whole system will not be fixed without higher staffing levels and greater protections for nurses and patients.

Not surprisingly, the vast majority of nurses strongly support laws and policies designed to bring about staffing levels that are safe and adequate (see Table 3), including:

- improved inspection and monitoring of hospitals;
- requirements that hospitals staff according to the acuity of patients;
- required staffing minimums for hospitals receiving federal funds;

> "I think there needs to be minimum staffing guidelines, like in California. I think legislation needs to be passed about staffing that says, 'yes, you ought to have a nurse who comes to see you in your room in the hospital.' Or, 'there ought to be X amount of nurses who actually work on the floor.'"
>
> REGISTERED NURSE, SYRACUSE

- written staffing plans and set minimum nurse-to-patient ratios for each unit;
- protections for nurses who report unsafe staffing levels; and
- restrictions on mandatory overtime.

What nurses are saying is that the only real and lasting solution to the nursing shortage is to set standards for safe staffing that hospitals and other health care facilities must follow.

TABLE 3
NURSES OVERWHELMINGLY SUPPORT SAFE STAFFING LAWS

Percent of registered nurses who favor legislation:

Protecting nurses from retaliation for blowing the whistle on unsafe staffing levels or conditions	94%
Requiring hospitals to adjust the number of staff in each unit according to acuity measurements	89%
Requiring minimum safe staffing levels of all hospitals that receive federal funds like Medicare reimbursements	89%
Calling for visits by inspectors or accrediting agencies that are not announced in advance for the purpose of monitoring whether the hospital is following its staffing plan	83%
Requiring hospitals to staff units according to a staffing plan or written guidelines that set the number of nurses per patient in each unit	80%
Setting minimum nurse-to-patient ratios for each unit	79%
Banning mandatory overtime except when there is a declaration of emergency	77%
Giving patients and the public access to a hospital's staffing plan and actual staffing levels	68%

Source: The Feldman Group Inc., SEIU Nurse Alliance, January 2001

Recommendations

Adopt federal and state laws to set safe staffing standards.

The health care industry is largely unregulated when it comes to the quality of patient care. With remarkably few exceptions, the nation's hospitals and other health care facilities are not bound by legal staffing standards, and health care employees are not covered by specific whistleblower protections or overtime restrictions.

In the absence of federal or state laws, hospitals have cut nurse staffing levels to bare-bones minimums — and rely on mandatory overtime and other short-sighted strategies to accommodate fluctuations in patient census and emergency needs.

Recognizing that a lack of staffing standards in today's managed care environment jeopardizes the safety of patients, the state of California recently passed a law requiring fixed minimum staff-to-patient ratios in hospitals. Today, a number of other states are considering similar legislation.

Federal and state governments must expand on these efforts if the nation's staffing crisis is to be solved. The Congress and state legislatures should enact safe staffing legislation that would:

■ *Set enforceable minimum staffing standards linked to the acuity of patients to ensure good quality care.* Hospitals, emergency rooms, and outpatient facilities must be staffed in a manner that guarantees sufficient, appropriately qualified nursing staff to meet the individualized care needs of patients. Minimal staffing requirements should be developed with the input of direct-care nursing staff and based on the number of patients, level of acuity, and intensity of care needed to ensure good patient outcomes. Hospitals should be required to submit annual staffing plans to the state, maintain daily staffing records, and post staffing levels for the public.

■ *Establish a ban on mandatory overtime and set maximum hours for nurses.* Mandatory overtime restrictions already exist in other industries, such as in transportation, where the public's safety is at risk. For nurses, who bear ultimate responsibility for the well-being of their patients, mandatory overtime should be limited to strictly emergency situations.

■ *Provide whistleblower protections for nurses who speak out about staffing problems that jeopardize patient care.* Nurses who are afraid to report unsafe conditions cannot effectively advocate for their patients. Employers who attempt to retaliate against nurses who in good faith report staffing practices that endanger patients should be subject to strict penalties.

Establish meaningful oversight and regulatory standards for hospitals.

The organization with the primary responsibility for overseeing the quality of care in the nation's hospitals is not a state or federal health agency, but the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) — an agency operated and funded by the health care industry itself.

Approximately 80 percent of hospitals in the United States use JCAHO to survey and certify their premises, and JCAHO accredits 99 percent of the hospitals it inspects every year. No public agency is assuring that JCAHO is doing its job adequately.

At a time when understaffing and medical errors are reaching crisis proportions, the hospital industry needs effective oversight.

Specifically, lawmakers and public officials should:

■ *Reform JCAHO's inspection procedures.* Currently, hospitals are notified well in advance of the inspection date for their triennial survey — and tend to be adequately staffed during these inspection periods. Surprise visits for all inspections, more opportunities for nurses and other hospital employees to meet privately with JCAHO inspectors, and true and accurate assessments of hospitals' staffing levels are more likely to uncover understaffing and other problems that jeopardize the safety of patients. JCAHO's inspection procedures should guarantee confidentiality and provide whistleblower protections for health care employees. Absent such reforms, JCAHO's role should be limited to a consulting one and an alternative means for genuine oversight of the hospital industry should be sought and instituted.

■ *Provide for more active oversight by the Health Care Finance Administration (HCFA).* HCFA, the agency of the Health and Human Services (HHS) Department to which JCAHO reports, currently is not actively involved in monitoring or regulating the standards that JCAHO measures. Following the recommendation of the Inspector General of HHS, HCFA should function as a public watchdog and hold JCAHO accountable. HCFA's 1997 proposed "conditions of participation" regulations on staffing should be strengthened and implemented.

"The hospital administrators should be asking, 'Why are we having a nursing shortage?' They should try to find out why lots of nurses are leaving bedside nursing. They have to find out what is wrong with the system before they can solve the problem."

REGISTERED NURSE, LOS ANGELES

Ensure that direct-care nurses have a voice in staffing and patient care decisions.

Nurses on the front lines know best what patients need. They know what works — and what doesn't. When staffing decisions are made without the input of nurses, as they typically are, patients suffer.

■ *Guarantee the input of nurses in staffing standards and quality oversight.* Laws and regulations governing hospitals should guarantee that nurses have a voice in the development of staffing plans. HCFA's proposed conditions of participation regulations, for example, should be revised to call for nurse involvement in staffing methodology — such as the choosing of acuity tools and patient classification systems — and the process for determining staffing levels.

■ *Support the efforts of nurses to work together for a voice in staffing and policymaking in their hospitals.* By forming unions, nurses are able to participate in decisions about staffing, improve working and patient care conditions, and enhance recruitment and retention in their hospitals. Public policies should support the efforts of nurses to work together in unions to protect the quality of care and their professional standards.

Promote retention — not just recruitment — in the nursing profession.

Current initiatives to ease the nursing shortage by expanding tuition assistance and nursing school recruitment programs are a step in the right direction. But putting all of our resources into recruitment will only create a revolving door. As long as they are overloaded and unable to provide quality patient care, nurses will continue to face high levels of frustration, stress, and injuries — and look elsewhere for careers that provide greater rewards and satisfaction.

The key to improving working conditions for nurses is to establish safe staffing standards, a ban on mandatory overtime, and whistleblower protections. But policymakers should look at other ways they can help make the nursing profession a more attractive one.

■ *Establish policies to improve working conditions for nurses and enhance the quality of the profession.* Nursing is a physically and emotionally demanding job, particularly for the aging nursing population. Public policies should encourage hospitals and other health care facilities to accommodate the needs of nurses of all ages by: providing adequate support staff and equipment to lighten the physical aspects of the job, offering shorter shifts and workweeks, implementing safety measures to reduce injuries, making child care available, eliminating responsibility for non-nursing duties, and alleviating the growing burden of paperwork brought on by managed care. Equally important, nursing salaries and benefits should be increased to reflect the level of education and responsibility required.

■ *Ensure that the nation's job safety laws adequately protect the health of nurses and prevent injuries.* The recent move to dismantle new Occupational Safety and Health Administration (OSHA) ergonomic standards that would have reduced injuries among nurses and other health care employees reflects a dangerous disregard for the nation's safety. To adequately protect employees in one of the nation's most dangerous occupations, OSHA standards must be strengthened and better enforced.

The pressure to cut costs, understaffing, and the rising rate of medical errors — all are symptoms of a health care system that puts the financial bottom line ahead of quality patient care.

More than 40 million Americans today are uninsured, and many more are underinsured. The growing ranks of the uninsured contribute to rising costs and put additional strain on health care providers. Only by guaranteeing health care security for everyone can we produce a health system that works for nurses and patients.

ENDNOTES

1. *To Err Is Human: Building a Safer Health System,* Institute of Medicine (IOM) of the National Academy of Sciences, 1999.

2. "The National Nurse Survey" conducted by the Service Employees International Union (SEIU) in 1992 was released in January 1993. Survey questionnaires were mailed to 47,000 registered nurses and licensed practical nurses represented by SEIU. More than 10,000 nurses completed and returned the questionnaire.

3. *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?,* Institute of Medicine (IOM), Division of Health Care Services, 1996.

4. "The External Review of Hospital Quality: A Call for Greater Accountability," Office of Inspector General, U.S. Department of Health and Human Services, July 1999.

5. *To Err Is Human,* IOM, 1999.

6. The IOM report called for performance standards around patient safety and increased accountability at the executive level, but only superficially addressed the link between staffing levels and medical errors. In its response to the IOM report, SEIU said: "Adequate staffing in our health care facilities is the foundation of safe patient care, and therefore any plan to reduce medical errors must address the dual epidemics of understaffing and the excessively long hours required of interns, residents, nurses, and other health care workers." SEIU's recommendations for preventing medical errors included: incorporating standards for staffing, working conditions, and work practices in performance standards; confidentiality and whistleblower protections for health care employees who report medical errors; and a comprehensive and effective system for monitoring and holding health care institutions accountable for failing to adequately address patient and worker safety concerns.

7. For the purposes of this survey, high-acuity patients were defined as those having multiple compromised organ systems requiring complex interventions.

8. A nationwide survey of 1,232 nurses and other health care professionals commissioned by SEIU and conducted by Peter D. Hart Research Associates, Inc. The survey findings were presented to the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry in December 1997.

9. "Nurse Staffing Levels and Adverse Events Following Surgery in U.S. Hospitals," Christine Kovner, PhD, RN and Petter J. Gergen, MD, MPH, *Image: Journal of Nursing Scholarship,* Fourth Quarter 1998.

10. "A Multisite Study of Nurse Staffing and Patient Occurrences," M.A. Blegan and T. Vaughn, Nursing Economics, 16 (4), 1998.

11. The National Nurse Survey, SEIU, 1992.

12. Bureau of Labor Statistics, U.S. Department of Labor.

13. "Trouble in the Nurse Labor Market? Recent Trends and Future Outlook," Peter J. Buerhaus, Health Affairs, January-February 1999.

14. *Nursing in California: A Workforce Crisis;* J. Coffman, J. Spetz, J.A., Seago, E. Rosenoff, and E. O'Neil; California Workforce Initiative and the UCSF Center for the Health Professions, January 2001. "Hard Numbers, Hard Choices: A Report on the Nation's Nursing Workforce," Edward Salsberg, Director, Center for Health Workforce Studies, School of Public Health, University of Albany, presented at a Center for Health Policy Research & Ethics forum, Feb. 14, 2001.

15. "The Registered Nurse Population: National Sample Survey of Registered Nurses," Health Resources and Services Administration, U.S. Department of Health and Human Services, 2001, 1997, 1993, 1989.

16. National Nurse Survey — March 2000, Preliminary Results, U.S. Department of Health and Human Services, Health Resource and Services Administration, Bureau of Health Professions, Division of Nursing, February 2001.

17. "Policy Responses to an Aging Registered Nurse Workforce," Peter I. Buerhaus, Douglas O. Staiger, and David I. Auerbach; Nursing Economics, v. 18, no. 6 (November-December 2000).

MICHIGAN CHAMBER OF COMMERCE

To: House Labor Committee

From: Wendy Block, Michigan Chamber of Commerce WB

Date: July 17, 2007

Re: House Bill 4339: Nurse-to-Patient Staffing Ratios & Mandatory Overtime

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The purpose of this memorandum is to inform you of the Michigan Chamber's opposition to House Bill 4339. The Michigan Chamber recognizes the significant challenges to the health care profession relating to shortages of trained personnel in nursing and other specialties due to increased utilization and an aging population. However, the Chamber is opposed to HB 4339 because we believe issues such as mandatory overtime and nurse-to-patient staffing ratios should be addressed in the workplace by hospital employers and employers, not by state or federal legislation that ignores the needs of patients and the communities in which they live.

The Michigan Chamber believes HB 4339 is capable of having the opposite effect of their stated purpose. The critical shortage of nurses in Michigan and nationwide could cause hospitals to have to curtail services and close beds if they are faced with having to fill a one-size-fits-all ratio. Further, we believe a one-size-fits-all approach to the state's hospital system would be risky, inefficient and wasteful because ratios do not take into consideration the ongoing assessment of patients' needs, the differences in the skill levels of nurses, the availability of other ancillary workers and support services, or the types of equipment and technology available in a particular hospital.

The Michigan Chamber believes it is imperative for hospitals to have the flexibility to manage staffing based on patient needs and the skills and competencies of their staff—without governmental interference. A better approach to this issue would be to bring all stakeholders together to work collaboratively to expand enrollment in nursing programs, break the barriers to entry into the nursing profession, encourage the retention of existing nurses, and/or improve quality and safe care in hospitals through sound management and marketplace solutions.

Please feel free to contact me at 517.371.7678 if you have any questions.

Foote Health System **Human Resources**

205 N. East Avenue, Jackson, Michigan 49201
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TO: Members of the House Labor Committee

FROM: Jan Blair, Vice President Human Resources
Foote Health System Jackson, MI

DATE: July 15, 2007

SUBJECT: **HB 4339 – 4341 Nurse Staffing and Overtime**
Position: Oppose

As a healthcare executive responsible for human resources, I wish to state my opposition to House Bills 4339, 4340, and 4341. The State of California enacted similar legislation in 2004, mandating staffing ratios and bans on non-voluntary overtime, which has proven ineffective in improving patient care, access, and nursing turnover rates.

The Bureau of Labor Statistics states that the nation faces a shortfall of more than 1 million nurses between now and 2014. The root cause of the nursing shortage lies in a lack of educational programs, qualified faculty, and sufficient training sites to meet demand. Governor Granholm's proposed "Nursing Corp" plan to focus funding and efforts on recognized barriers to the nursing workforce supply is a step at addressing the root causes. At Foote Health System, we have developed partnerships with our local community college and with area universities to create innovative programs to accelerate the training process, offer educational scholarships and stipends, and help provide and sponsor educators and clinical training sites.

This legislation has a very basic assumption that all patients, nurses, support staff, and facility types are the same 24 hours a day, 7 days a week, which is not a reflection of reality in healthcare. Nursing leadership has developed staffing plans that reflect the care demands of the patients that can vary by time of day and day of the week. In addition, many other variables have been identified as important to patient outcomes, including the experience and educational preparation of the nurse, the availability of technology (such as computerized physician order entry) to support the nurse, the availability of support staff (nurse assistants, unit-based pharmacists, etc), and a strong nurse-physician collaboration. We participate actively in MHA's Keystone Center for Patient Quality and Safety, a voluntary hospital quality improvement initiative that has gained national and international attention for its impact on quality of care and clinical collaboration. We recently won a state-wide award for our rapid response program, which recognized that we successfully did early intervention on patients and took steps to avoid a crisis.

I believe that the nursing leadership and the human resources leadership in this state can work together to create environments that are efficient, safe for patients and satisfying to nurses. Alternatives to mandatory staffing ratios involve the use of patient classification

systems and acuity-based staffing grids to support the professional judgment of the registered nurse in making staffing decisions. At Foote Health System, we benchmark ourselves to the guidelines published by certifying, state and national regulatory agencies, as well as staffing recommendations developed by national nursing specialty organizations that define and evaluate evidence of safe staffing patterns, educational preparation and competency levels of direct care staff. Finally, research shows that the workload of the registered nurse is impacted by such factors as availability and skill sets of ancillary support staff, organizational resources and structures, nurse-physician relationships, the availability of clinical technology support, electronic medical records, and the experience level of staff.

The documented results from California indicate that legislatively directed staffing ratios have led to significant nursing dissatisfaction, resulting in further nursing shortages and, in some cases, hospital and unit closures, all of which adversely affect patient care. With Michigan's economic challenges, this bill could affect one of the few industries in the state that is actively growing.

In daily practice, we have been successful in voluntary response from staff to work additional hours, ranging from part-time and casual/on-call staff working extra hours to using managers and nurse educators in a direct caregiver role and utilizing agency nurses. In addition, we offer competitive "on call" incentives, which entice staff to work extra.

In summary, I believe that taking steps outlined above to address the nursing shortage are much more effective than legislatively mandating arbitrary ratios and imposing steep financial penalties and licensure sanctions against hospitals.

Spectrum Health

100 MICHIGAN STREET NE GRAND RAPIDS MI 49503-2560
616 391 1065 FAX 391 2870 *shawn.ulreich@spectrum-health.org*

Shawn M. Ulreich RN MSN
Chief Nursing Officer
Vice President Patient Care Services
Spectrum Health Hospitals Grand Rapids

July 17, 2007

Chairman Miller, members of the committee, good morning, my name is Shawn Ulreich and I have been a registered nurse for 27 years. I have been VP for Patient Care Services and Chief Nursing Officer for Spectrum Health Hospitals for the past 3 years and prior to that spent 19 years at the Cleveland Clinic, including 5 years serving as the CNO.

Spectrum Health believes that the safety of patients within our facilities and the quality of care they receive is our number one priority. Providing safe staffing by a workforce that is physically and emotionally rested is a desire for all hospital administrators. I do not believe, however, that mandating the number of patients to each nurse will achieve this goal, and therefore, am here before you to express our opposition to House Bill 4339. Let me explain our three reasons:

First – we are in the midst of a national nursing shortage. Within the next 3 years, our state will be short 7000 nurses and by 2015 (the time many of us will be at the highest level of medical needs) we will be short 18,000. To mandate ratios in a time of shortage will likely lead to increased cost – because hospitals will need to pay nurses even higher wages to get them to work extra shifts. Many hospitals currently pay premiums to nurses at various times to "entice" nurses to work more. With mandated ratios, the frequency of the enticements most likely would increase. Every CNO that I know would gladly ~~higher~~ hire more nurses, ***if they were out there to hire.*** Another reality today is the number of nurses who work on a part-time basis. In our organization 40% work part time. This is a life style choice which all organizations must respect yet realize the challenge that this poses.

Our second reason to oppose this bill surrounds the issue of nursing experience and skill set. Not every nurse has the same level of experience. A nurse who has just become a registered nurse versus a nurse with 7 years of experience – can usually handle different case loads. Hospitals strive

Legislative involvement and monitoring of this practice is unnecessary and would create an administrative burden.

I join with you in your desire to provide safe care to patients and would look forward to exploring other potential solutions .

I'd be happy to answer any questions you may have. Thank you.

TRINITY HEALTH

Novi, Michigan

HOUSE BILL 4339

On behalf of the 27,500 Trinity Health associates in Michigan (including 3,500 RNs), I thank you for allowing me the opportunity to testify in opposition to legislation that would impose minimum Nurse-to-Patient Staffing Ratios in Michigan. I am Gay Landstrom, RN, Director of Nursing Practice for Trinity Health.

Trinity Health Michigan is 11 hospitals, 40 continuing and long-term care facilities, and 20 subsidized health clinics located across the state of Michigan. With a $1.1 billion payroll, we are one of the state's largest employers. Nationally, Trinity Health is one of the top ten largest health systems in the country.

Because of our national presence, we have addressed similar legislation in other states, including California. We believed then, as we do now, that nursing staff ratios is not the solution. Just as we've experienced in California, passage of this bill alone will not improve nurse satisfaction nor will it improve patient care at our Michigan hospitals. Following are example of initiatives that will, and have, improved nurse satisfaction and patient care.

We believe nurses are vital to ensuring that patients receive quality care and are satisfied with their hospital experience. Trinity Health values its nurses and is committed to providing environments where nurses want to practice. Our approach to enhancing the practice of nursing is three-fold: empower nurses as decision-makers, invest in nurse education, and leverage technology to enable nurses to work more efficiently.

Empowering Nurses as Decision-makers

- Research has consistently shown that nurses want control over their environment and the way they practice their profession and provide care. Trinity Health seeks to continually empower RNs with authority over their practice, including how the unit and shift is staffed. Development has just started on forming corporate-wide nursing decision-making bodies to further the empowerment already happening at the hospital level.
- Magnet Recognition Program. The Magnet Recognition Program was developed by the American Nurses Credentialing Center to recognize health care organizations that meet 14 stringent criteria around nursing care. It is based on nationally recognized quality indicators and standards of nursing practice. Two criterion address staffing. However, they require that staffing systems be able to adapt and flex to internal and external factors such as staff illness, unanticipated shifts in workload, patient needs, staff member skill sets, and staff mix. The documented result of Magnet status is top tier quality, improved nurse satisfaction, and greater application of best practices.

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Michigan Ministry Organizations:

Battle Creek Health System
Patrick R. Garrett
President and CEO

Mercy General Health Partners
Roger Spoelman
President and CEO

Mercy Hospital – Cadillac
John L. McLeod
President and CEO

Mercy Hospital - Grayling
Stephanie Riemer Matuzak
President and CEO

Mercy Hospital – Port Huron
Peter Karadjoff
President and CEO

Saint Joseph Mercy Health System
Garry C. Faja
President and CEO

Saint Mary's Health Care
Philip H. McCorkle Jr.
President and CEO

St. Joseph Mercy Oakland
Jack Weiner
President and CEO

St. Mary Mercy Hospital
David Spivey
President and CEO

Trinity Continuing Care Services
Jacklyn Harris
Chief Executive Officer

Trinity Home Health Services
Grace McCauley
Chief Executive Officer

- Our Magnet hospital in Dubuque IA has the lowest turnover rate of all hospitals in our system at less than two percent. Nationally, the average is above 15%. Recently, each of our hospitals accepted the challenge to pursue the Magnet standards and begin the journey of obtaining Magnet Recognition.

Investing in Nurse Education

As reported in a 2003 Journal of the American Medical Association article, patient outcomes are most correlated to the level of training of the nursing staff not the number of nurses employed. Likewise, nurses report a strong desire to have upward mobility in their profession, an opportunity that can only be reached with advanced training.

- Several of the Michigan Trinity Health hospitals have on-site BSN completion programs, where educational costs for RNs to complete their BSN are heavily subsidized by the hospital.
- Clinical Nurse Leader program. The American Association of Colleges of Nursing developed the Clinical Nurse Leader role, a new nursing role that uses expertise and knowledge to guide the care of patients. It is being implemented at hospitals across the country including the entire VA system. Ours includes a partnership with the University of Detroit Mercy. These master's degree-prepared clinicians oversee care coordination of patients, put evidence-based practice into action, and have decision-making authority to change care plans when necessary.
- Trinity Health's Foundations in Leadership Program provides education to new and future nurse leaders, an opportunity for individual development for nurses, and one that helps ensure a consistent, satisfying work environment for staff nurses.
- Scholarship opportunities. Every Trinity Health MI hospital offers tuition reimbursement as well as scholarships for RNs to purse their BSN or Masters' degree.

Leveraging Technology

As you know, the Institute of Medicine, through its "To Err is Human" report, has brought significant attention to the need to address medical errors. This report quantifies the patient safety concerns that many of the nurses who have already testified before this committee have so passionately articulated. In 2003, the Institute of Medicine issued another report that validates the role nurses play in patient safety. The report, titled, "Patient Safety: Achieving a New Standard for Care" identifies health information technology as the solution for dramatically reducing preventable medical errors.

- Trinity Health concurs that new information technologies and automation can create efficiencies that result in improved patient outcomes as well as valuable supports for nurses.
- Trinity Health Michigan has invested more than $200 million dollars in new technology such as electronic health records, bedside barcode scanning for safe medication delivery, computerized physician order entry systems and electronic prescribing, and safer "smart" IV pumps.
- As a result of these efforts, we have already seen an 8 percent increase in the time our nurses spend delivering nursing care to patients at the bedside. Leveraging technology to provide our nurses opportunities to spend more time at the patient bedside will continue to be a top priority.

We believe that legislation to mandate nurse-to-patient staffing ratios would actually make it harder for us, and other health systems, to continue initiatives like I've just highlighted that enhance the practice of nursing. This has been our experience in Fresno, CA. Rather than providing registered nurses with a sense of security and safety, the California legislation actually took away a considerable amount of nurse decision-making. Because the California law requires that a certain ratio be maintained at all time, a nurse no longer has the freedom to decide when the best time for lunch is based on her patient's needs. And because the law addressed "nursing staffing", ancillary staff that support the nurse and enhance her or his work environment were let go in order for those dollars to be used for nursing staff salaries. Nurses have lost their assistive colleagues, having to return to emptying trash and other menial tasks that make poor use of their expert nursing skills.

Units have had to temporarily or permanently close if they did not have staff to meet the ratios, limiting access to care for the community. Additionally, resources that could have been directed toward nurse education scholarships and new technology are instead being diverted to staffing.

Lastly, we have found the ratios to be very rigid and unresponsive to the needs of nursing teams. For instance, one unit can have a very experienced, senior team with excellent communication and teamwork. They don't find a need for as much staff as the California ratios dictate. On the next unit, you can have a younger team, with less experience, novice communication skills and poor teamwork. This unit must be staffed differently than the mandated ratios prescribe. The ratios would not be enough for this team to function well, while the next unit has "extra" and is not allowed to help the younger unit in need. We have found the rigid dictates of the ratios to ignore the realities of team dynamics and needs, sometimes creating the unsafe conditions they seek to avoid.

We do believe the Michigan legislature should play a role in enhancing the practice of nursing and we commend you for your interest. Efforts that recognize the vital services nurses provide and provide nurses opportunities to expand their skills would be embraced by nursing and health care systems alike. Trinity Health humbly suggests that your approach be one that builds upon current successes and invests in nurse education, supports initiatives that empower nurses as decision-makers, and encourages further leveraging of technology.

Thank you for the opportunity to testify.

Beaumont Hospitals

July 17, 2007

Members, House Labor Committee

Dear Representative:

On behalf of Beaumont Hospitals, we are writing to express our opposition to House Bill 4339. Beaumont supports the goals of this legislation: to assure quality patient care, reduce nurse burnout, and prevent nurses from leaving the profession. However, Beaumont Hospitals have initiated strategies other than mandated nurse ratios to meet these goals, which we believe are preferable. Our lower nurse vacancy rate, compared to other hospitals, is a sign that nurses find practicing their profession at Beaumont to be a rewarding experience.

Beaumont Hospitals in Royal Oak and Troy are among the busiest hospitals in the country for hospitals their size; they have the highest occupancy rates of all hospitals in Michigan. The RN vacancy rate at the Beaumont Hospitals is 5.6 percent--below the national average of 8.5 percent--and our turnover rate is 8.2 percent, also below the national average turnover rate of 13 to 36 percent. We do not mandate overtime, but neither do we always staff at the minimum levels required under House Bill 4339.

Our philosophy is to empower our nurses to create an environment where nurses want to practice and feel fulfilled in their roles. This philosophy was recognized and rewarded when Beaumont, Royal Oak became the first hospital in Michigan and the 100th in the nation to be designated by the American Nurse Credentialing Organization as a Magnet hospital, one which attracts nurses to practice their profession. Our Troy hospital is now in the process of completing its application for Magnet designation.

The following are some of the initiatives we have implemented to empower our nurses, which allows them to make decisions to make their jobs better, and assure quality care to our patients:

1. Both Beaumont hospitals have Professional Nurse Councils (PNC), with a nurse representative from each nursing unit in the hospitals chosen by his or her fellow nurses on that unit. The PNC nurses elect their own chairperson. This group has the opportunity to learn the "big picture" issues facing our hospitals, such as changes in reimbursement, and to identify and solve patient care issues.

2. Our nurses were involved in the evolution of establishing and training supportive personnel, who serve as nursing assistants or perform duties that allow the RNs to use their knowledge and experience to assess patient care needs, and spend less time on non-nursing requirements. In other words, nurses have more time to practice their profession. These assistants augment, not replace, the work of our RNs.

Corporate Administration
3711 W. Thirteen Mile Rd.
Royal Oak, MI 48073-6769

non-nursing requirements. In other words, nurses have more time to practice their profession. These assistants augment, not replace, the work of our RNs.

3. The development of an in-house nursing pool comprised of part-time and contingent nurses who are called when one of the scheduled nurses is unable to work due to illness or family emergency and to fill in for vacations. Rather than hiring outside agency nursing personnel who are not familiar with Beaumont, we rely on our own pool nurses to voluntarily work additional hours to fill in when necessary.

4. A rapid response team (RRT) comprised of nurses, respiratory therapists, and physician extenders that can be called by any nurse when a patient begins to show signs of a decline in their condition. The RRT staff provides additional support to the nurses in treating the patient, and also frees up the RN to spend time with the other patients for which he or she is responsible. As a result, we have seen improved clinical outcomes through medical stabilization and recovery.

5. Implementation of a dedicated RN admission team to perform all nursing patient assessments on admission, a process that can take up to one hour per patient. Prior to the implementation of the team, there were often delays in the floor nurse being able to complete this initial assessment while caring for other patients, resulting in the patient plan of care being delayed. The team has added much support to the bedside nurse by taking away the initial patient assessment responsibility, tremendously increasing their satisfaction. The patients have also been very satisfied with this process.

Each of our nursing units is included in the development of their own staffing schedules and ratios. They have the latitude to take responsibility for calling in an additional nurse when they feel they need more help based on the conditions of the patients, or when more patients are admitted to the floor.

Beaumont supports other legislative initiatives to increase the supply of nurses and participates in nursing scholarship and tuition loan programs. However, we believe there are better alternatives than mandated nurse-to-patient ratios to achieve the goals of quality patient care and providing an environment that attracts and retains our valued nurses.

Thank you for your consideration.

Sincerely,

Val Gokenbach
Vice President and
Chief Nurse Executive
Beaumont, Royal Oak

Nancy Susick
Vice President and
Chief Nurse
Beaumont, Troy

HURLEY

Patrick R. Wardell
President & Chief Executive Officer

July 11, 2007

The Honorable Fred Miller
Attn: Ms. Smith
Michigan House of Representatives
N 0899 HOB
124 North Capitol
P.O. Box 30014
Lansing, MI 48909-7514

RE: Submission of Written Testimony - Hurley Medical Center's Opposition to Legislatively Mandated Nurse-Patient Staffing Ratios - HB 4341

Dear Representative Miller:

I understand the Committee on Labor will be receiving public testimony on June 26, 2007, and again in July, on the above referenced bill that seeks to legislatively mandate nurse-patient staffing ratios. This letter is to express Hurley Medical Center's opposition to this proposed legislation for the reason that it is not in the best interest of Hurley or the communities we serve. We appreciate this opportunity to voice our concerns and ask that the committee take into account the numerous points discussed below in the upcoming proceedings on the subject.

First, we concur in the opinion of the Michigan Hospital Association (MHA) that state mandated ratios may present a conflict with federal emergency room treatment requirements. The federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to provide emergency treatment to any individual that comes to the emergency department. A hospital may violate the proposed state staffing ratio mandate for treating an emergency patient as required by federal law in some instances, if the hospital did not meet the nurse-to-patient ratio at a given moment. Despite this federal law requirement, Hurley Medical Center treats all patients without regard to their ability to pay pursuant to our public mission. Nevertheless, a violation of the federal law may unintentionally occur frequently at Hurley since we are often faced with the common situation referred to as "overcrowding" in the emergency room. We, at Hurley, treat and care for more than 75,000 thousand patients a year in our emergency department, amounting to sometimes 1,400 to 1,500 patients weekly. Patients originate from the city of Flint, Genesee County, as well as 22 additional counties. (Please see the enclosed charts, which illustrate Hurley's patient geographical origins). Under the above circumstances, we may not always be able to comply with a predetermined, mandated nurse to patient ratio. I understand that in California, this scenario has caused hospitals to divert ambulances to more distant hospitals to avoid breaking the law, placing patients at greater risk. This proposed legislation would certainly also pose a legal dilemma for Hurley.

We have learned the following facts about the status of implementation of this type legislation in California:

- California's nurse staffing ratio legislation took effect in January 2004. Since then, 9 out of 10 California hospitals are still noncompliant with the law.
- The California Department of Health Services has granted waiver requests to hospital unable to meet the staffing ratios in order to maintain necessary patient access in the state.
- At least one California hospital, Santa Teresita, shut down as direct result of the staffing ratios. Other California hospitals have limited their patient capacity and diverted ambulances because of the staffing ratio mandates and penalties.
- Michigan's proposed legislation is even more stringent than California's AND California's law included a $68 million appropriation to improve the state's nursing workforce supply. Currently, Michigan's ability to allocate similar funding is in question.

Second, it is a well-known fact that Michigan and the nation face a severe and documented nursing shortage. Hospitals simply cannot maintain a supply of nurses that does not exist. Here are the compelling statistics on this point:

- The state will face a shortage of more than 7,000 nurses by 2010 — and 18,000 by 2015 — according to the Michigan Department of Labor and Economic Growth.
- The nation faces a shortage of more than 1 million nurses between now and 2014, according to the Bureau of Labor Statistics (Monthly Labor Review 2005).
- Despite this, patients will still seek treatment in hospitals. Closing hospital doors and forcing fines and other penalties on hospitals for fulfilling their mission of providing high-quality, cost-effective care is not the answer. Patients must continue to receive care while the long-term causes of the nursing shortage are addressed.

We believe the only way to address the nursing shortage is for health care providers to work together to address the crisis. The answer to the nursing shortage is addressing the root cause — a lack of educational programs, qualified faculty and training sites. It is a documented fact that hundreds of prospective nursing students are turned away from existing educational programs every semester due to lack of space. We, along with other MHA members, are committed to working with nurses, the education community, and policy makers to increase the number of high quality education programs and resources to address the nursing supply shortage. Michigan hospitals and learning institutions are offering scholarship programs for high school and college students — and career opportunities for displaced professionals — to enter the field of nursing. Some colleges and universities (Michigan State University, University of Detroit Mercy) are partnering with hospitals to offer accelerated, one-year nursing courses — getting qualified nurses into hospitals more quickly. We are aware that through a partnership with Oakland University, Henry Ford Health System has opened its nursing program to all displaced autoworkers. So, there are numerous efforts underway aimed at addressing this nursing shortage crisis that will be a far more workable solution than mandated ratios.

Finally, the September 2003 issue of the Journal of the American Medical Association (JAMA) published findings that demonstrate that lower mortality and failure-to-rescue rates for patients undergoing common surgical procedures are associated with both patient to nurse ratios, and having a majority of RNs educated at the baccalaureate level. Thus, health care professionals and care givers are best qualified to determine appropriate staffing needs based on a facility's patient mix, the training and experience of the nursing staff, and other relevant factors. When it comes to high-quality patient care, a one-size-fits-all approach is simply not the solution.

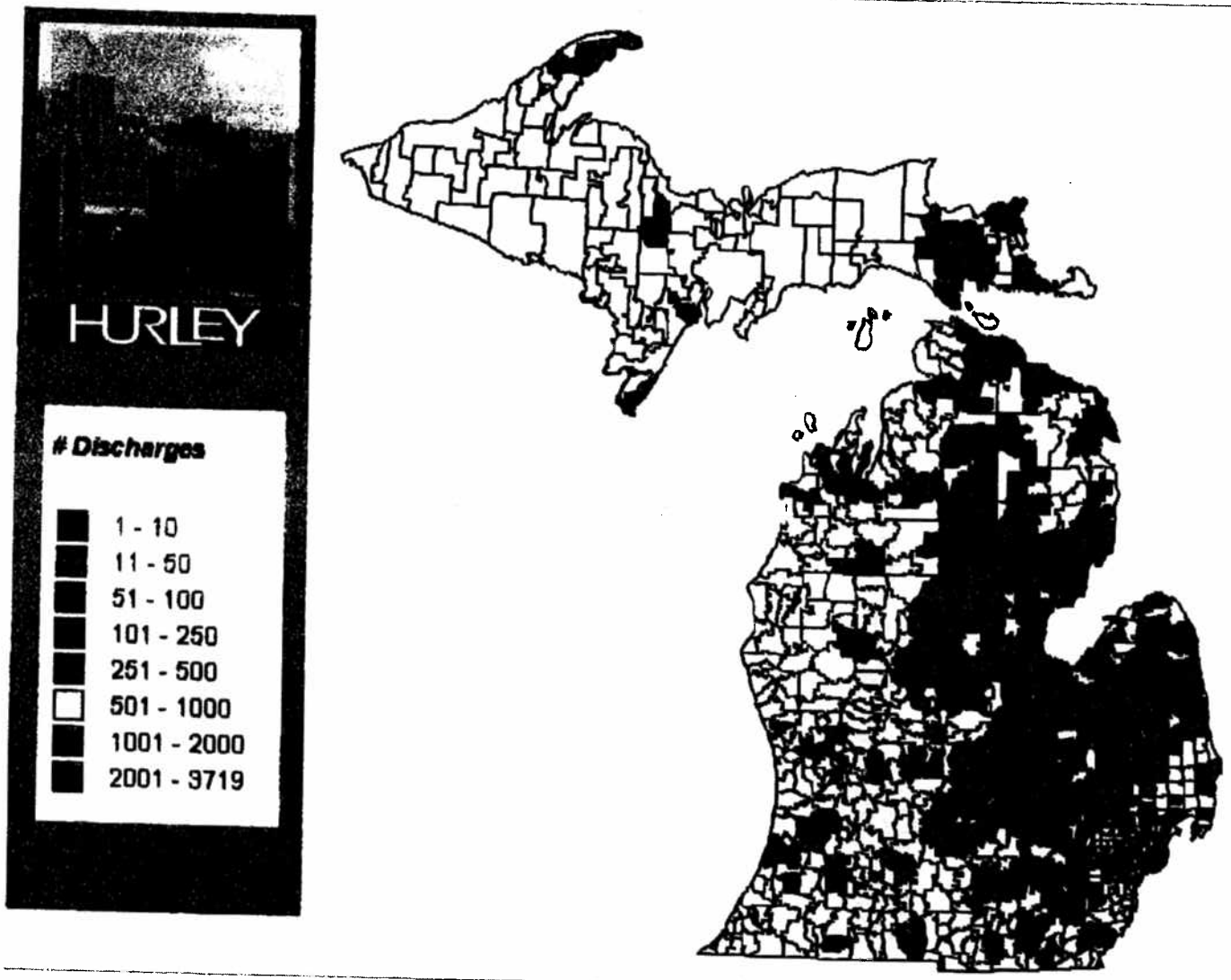
For all the above reasons, Hurley Medical Center opposes the proposed legislation and asks the members of the Committee on Labor to vote against its passage. If you have any questions please do not hesitate to contact me. Thank you for your time and consideration regarding this crucial health care issue.

Sincerely,

Patrick R. Wardell
President & Chief Executive Officer

CC: The Honorable John Gleason
The Honorable Deborah Cherry
The Honorable Brenda Clack
The Honorable Lee Gonzales
The Honorable Richard Hammel
The Honorable Ted Hammon

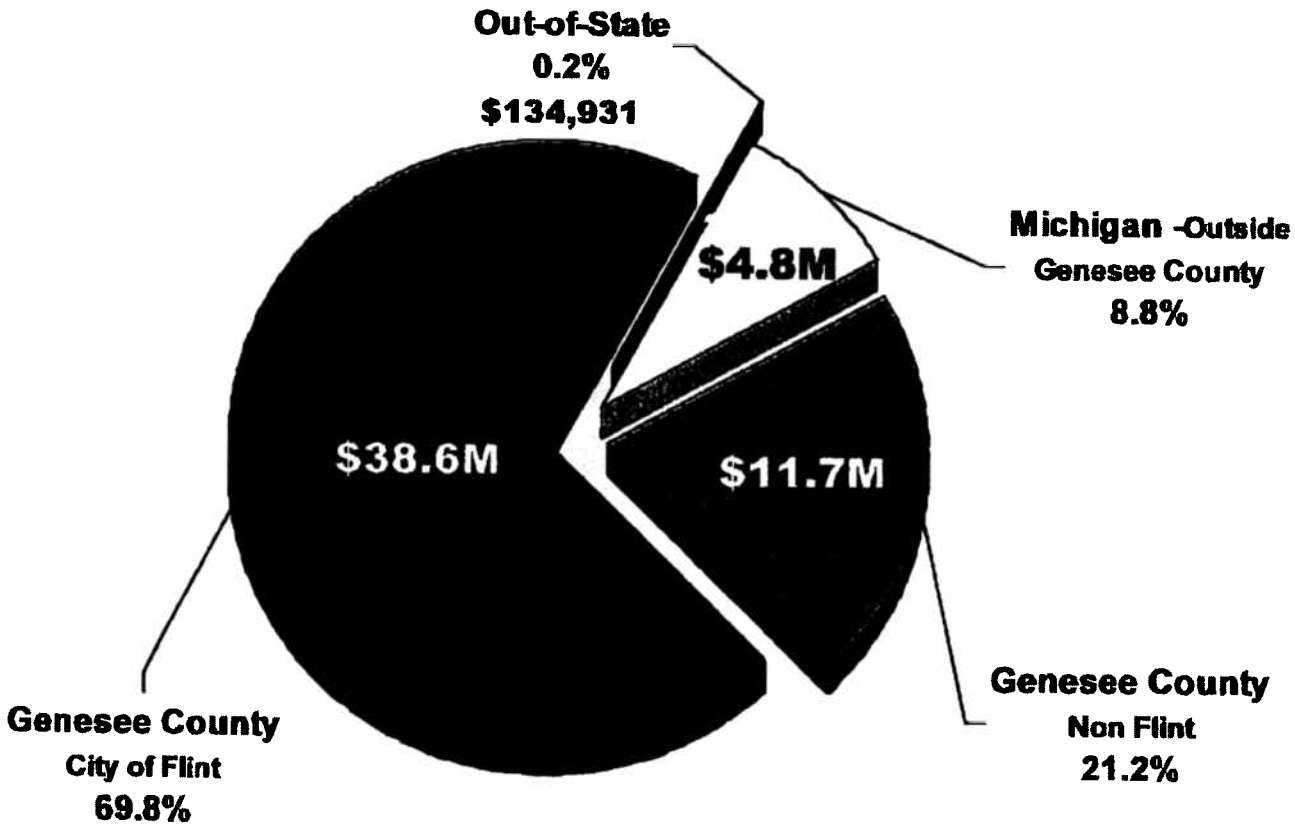
HURLEY STATEWIDE DISCHARGES – FY 2006



Source: MIDB

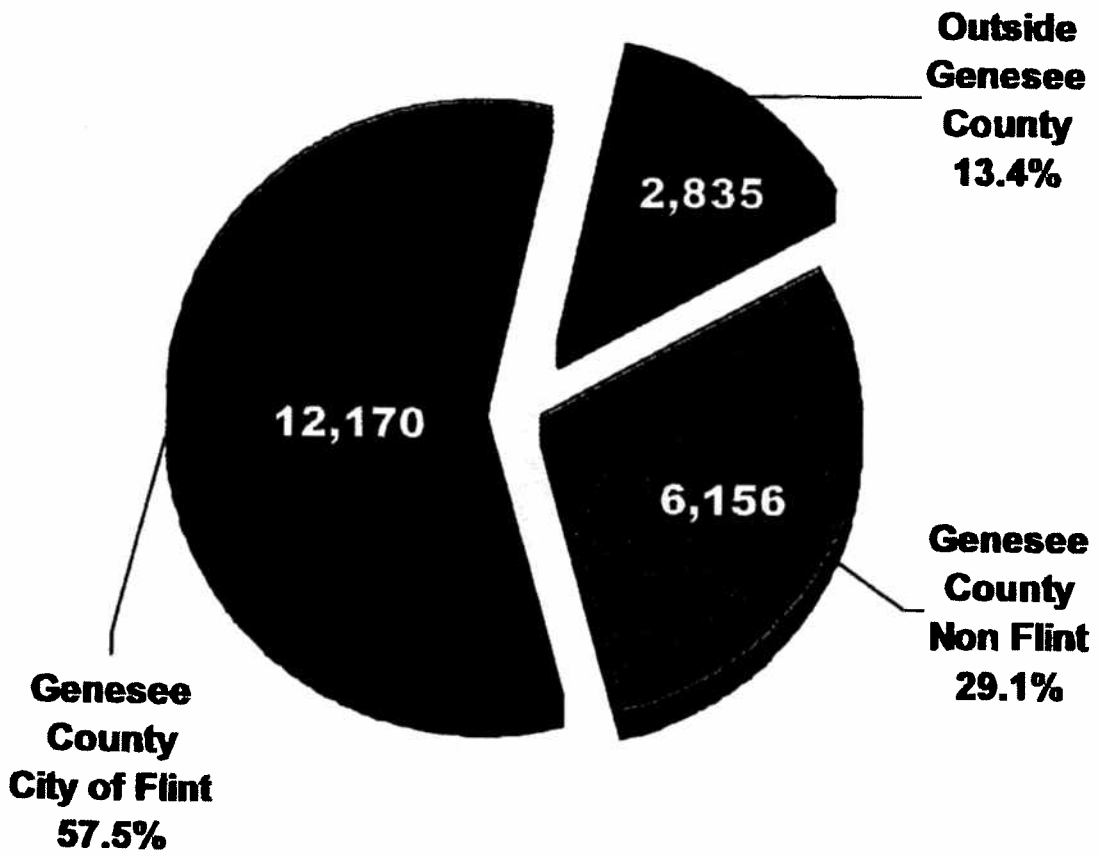
Hurley – Planning & Marketing

INPATIENT MEDICAID/MEDICAID HMO REVENUE – FY 2006



Source: Hurley Trendstar database

INPATIENT ORIGIN BY ZIP CODE – CY 2005



Source: MHA IDS

Talking Points: Mandatory Overtime

The Michigan Organization of Nurse Executives opposes legislation that would negate one option for delivering necessary health care services to patients by placing limits on the maximum hours of work allowed for nurses.

Mandatory overtime is an essential tool for hospitals to assure that patients receive necessary and adequate care. It is part of a complex set of staffing options that Michigan hospitals use to ensure consistent, high-quality care for their patients.

Mandatory overtime is an unavoidable consequence of the severe nursing shortage in Michigan and nationwide. Because of the severe nursing shortage, hospitals use mandatory overtime as one option to ensure continuity of care. Unavoidable overtime is only a symptom of a complex problem related to the severe shortage of nurses. In addition, it should be recognized that many nurses choose to work overtime, either within their primary place of employment or by working for more than one organization. If patient safety is the driving force behind this proposed legislation, it's incongruent to limit mandatory overtime without addressing voluntary overtime.

Hospitals use mandatory overtime as a last resort and avoid using it by:

- asking for volunteers
- calling in staff who have elected to be called or have accepted an "on call" incentive to be available for overtime
- asking part-timers or per diem staff to pick up extra hours or shifts
- drawing staff from a float pool or staffing pool
- using traveler or agency staff
- requiring managers and/or educators to work as direct caregivers
- limiting census

Unforeseen circumstances sometimes force health care providers to require staff to work outside of their normal schedules, including:

- unexpected high occupancies from outbreaks of illness or accidents
- unanticipated staff absences from unforeseen personal circumstances, such as illness or family emergencies
- unusually high patient-acuity levels
- weather-related problems
- disasters and other emergencies that cannot be anticipated

Mandatory overtime is not the preferred option to staff a hospital, but it must be available as an option. In rare cases, when all other alternatives have failed and care must be delivered to patients, the ability to require staff to stay is critical to patient safety and care.

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